Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE ELMCROFT OF TWIN HILLS MADISON, TN 37115 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) D 603 1200-08-25-.06 (1)(a)3. Administration Each ACLF shall meet the following staffing D603 and procedural standards: Corrective action for residents (a) Staffing Requirements: affected: 3. An ACLF shall have an identified responsible attendant who is alert and awake at all times and Resident #2 is no longer at this a sufficient number of employees to meet the facility. He was discharged on 12residents ' needs, including medical services as 24-2011 to the hospital. prescribed. The responsible attendant and direct care staff must be at least eighteen (18) years of Resident #5 is no longer at this age and capable of complying with statutes and rules governing ACLFs. facility. She was discharged on 2-14-2012 to a Nursing Home. The twenty two residents This Rule is not met as evidenced by: Based on medical record review, review of a identified as having needs the facility Aculty Discharge Planning report, review facility are unable to meet, have of a police report, review of facility staffing been appropriately discharged to schedules, observation and interview, the facility falled to provide sufficient staff to meet the needs a higher level of care. Two of the for two residents (#2, #5) reviewed and identified residents are in the twenty-two residents identified by the facility as process of discharge with having needs the facility was unable to meet. assistance from the Ombudsman. The findings included: They are resident's #33 and #40. Resident #2 was admitted to the facility on June Resident #33 is scheduled to go to 30, 2011 with diagnoses including Dementia. a nursing home. Resident #40 is scheduled to go to another facility. ..? Review of an Acuity Discharge Planning report dated December 9, 2011 revealed the resident This will occur when the family required care necessary in a secured unit (facility completes financial arrangements not licensed for secured unit). and CHOICE's approval. Medical record review of a Chart Note dated December 24, 2011 at 10:00 p.m. revealed "...discovered in room by care

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Executions Occeptor

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION COMPLETE SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 603 D 603 Continued From page 1 These two residents were attendant...bleeding from nose, ear, mouth, and assessed by a licensed nurse law appeared to be swelling...had beat (resident) utilizing the Elmcroft assessment with cane..." tool and their care needs were Review of a police report dated December 24, determined. The staff was in-2011 revealed "...Victim (Resident #2)...aggravated assault...blunt object..." serviced on what these two residents need in order to meet Review of the staffing schedule and interview with their specific staffing needs on the Resident Services Director (RSD) on February 1, 2012 at 1:48 p.m. in the Executive March 30, 2012 by the Resident Director's (ED) office revealed Medication Service Director. Supervisor #2, Care Associate (CA) #2, CA #5 and Medical Technician #3 were scheduled to Other Residents that could work the evening shift on December 24, 2011. potentially be affected: Interview with CA #2 on February 1, 2012 at 3:00 p.m. in the ED's office revealed CA #2 observed Per the Elmcroft policy, residents Resident #2 asleep between 7:30 p.m. and 8:00 will be provided sufficient staff to p.m. Continued interview revealed CA #2 returned to Resident #2's room at approximately meet their needs. As stated in the 9;45 p.m. and CA #2 stated, "...was covered with regulations, 1200-08-25-.12 under blood...bleeding from jaw, gobs out of nose, Resident Records, page 32 number coming from mouth (and) blood from right ear..." 4; An ACLF shall complete a Telephone interview with Medication Supervisor written assessment of the resident #2 on February 2, 2012 at 1:55 p.m. revealed the to be conducted by a direct care resident was forgetful and she stated "...needed almost total care...typically 2-3 caregivers and staff member within a time-period me..." determined by the ACLF, but no later than seventy two (72) hours Interview with CA #2 on February 9, 2012 at 11:25 a.m. In the marketing office revealed her after admission; however in all assignment on the evening of December 24, reasonable opportunities a 2011 included seven totally dependent residents. licensed nurse conducts the Continued interview revealed three caregivers staffed the facility after 8:00 p.m., (12-24-12) after assessment per our policy. It is CA #5 went off duty at 8:00 p.m. not acceptable practice for a Telephone interview with Police Detective #2 on



Addendum to D603

Complaint Survey March 1, 2012

Residents and Families complete a survey that is conducted by an independent third party annually. The Executive Director gets this information from these surveys and discusses with the other Directors. An action plan is submitted to the support center for follow up to ensure needs are met.

The facility conducts Resident Council Meetings monthly driven by the Healthy Lifestyles Director. Any concerns are followed up by the Directors to ensure needs are met.

The facility conducts monthly Family Meetings driven by the Executive Director. Any concerns are followed up by the Directors to ensure needs are met.

Signature of Executive Director

Date

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 603 D 603 Continued From page 2 Community Relations Director to February 7, 2012 at 10:05 a.m. revealed Resident conduct an assessment. A licensed #2 had expired, an autopsy had been performed nurse does an assessment per our and complications of blunt force trauma was the policy prior to move in, after 30 cause of death. days, every 6 months or upon a change of condition or return from Resident #5 was admitted to the facility on an alternative setting such as, September 11, 2009 with diagnoses including Pick's Disease. hospital, rehab/skilled care or home dependent upon the Medical record review of a General Note dated August 1, 2011 revealed "...total assist with ADL's residents needs as determined by (activities of daily living)...slouched over in the level of care assessment. wheelchair...repositioned several times, unable to sit up...non-ambulatory, non weight-bearing..." Medical record review of a Chart Note dated On March 8, 2012, all existing September 7, 2011 revealed "...was found on the residents were assessed by floor...hit the left side of...head no redness or licensed nurse per the policy to bruising..." ensure their appropriateness for Review of an "Acuity Discharge Planning" report Assisted Living. dated December 9, 2011 revealed "...total care..." Medical record review of Chart Notes dated December 11, 2011 revealed, "Took to room after lunch and resident slid out of chair and was on the floor...gash on left side of back of head...to (hospital)...returned, spoke with Dr. (doctor) stated he put staples in...head otherwise...looked fine..." Medical record review of an Emergency Provider Record dated December 11, 2011 revealed "...Time (2:52 p.m.)...Historian: paramedics NH (nursing home) notes...fell out of wheelchair...1.5 cm (centimeter) lac (laceration)..." Continued review revealed "...non-ambulatory at baseline...non-communicative at baseline...was unable to get a hold of staff...despite several. attempts. When spoke with Rn (Registered

| Division | i of Health Care Fac | lities | | | | | |
|--------------------------|--|---|-----------------------|----------------------------|---|--------------------------|--|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | | (X2) MULTI | PLE CONSTRUCTION | (X3) DATE SI COMPLE | |
| İ | • | TNPL53766 | | B. WING | | 03/0 | 1/2012 |
| NAME OF F | ROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | • | |
| ELMCRO | OFT OF TWIN HILLS | | | HILLS DRIVE I, TN 37115 | · | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM/ | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | COMPLETE DATE |
| D 603 | Continued From pa | rae 3 | | D 603 | | | |
| | - | were unable to proive | ia anv | | Measures and systematic ch | anges | |
| | further historical inf | formationstapled' | ic any | | to prevent recurrence: | | |
| | Review of a staffing schedule dated December | | | | and the state of the bushell | II. | |
| | 11, 2011 and interv | iew with the RSD on | February | } | The facility has weekly at risi | | |
| | 1, 2012 at 1:48 p.m | i, in the ED's office re | evealed | | which are designed to discus | stne | 1 |
| | | iclan's and a CA wer the day shift. The RS | | | resident Quality Services as documented on a log, driver | .bu | |
| | "There had to be as | nother caregiver but | | | the Quality Service Manager | | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |
| | t." | - | | | monitor the Resident Service | | ्रिको भूतिहा |
| | | cord Reports dated I | | | Director and Executive Director | | Jane 1993 |
| ٠ | | by the ED on Februa | | | This meeting is to ensure the | | 12.00 |
| | | r the two medical tec tion regarding the sci | | | facility can meet the acuity l | | |
| | CA or an RN. | | | | of the residents. | ئىيىرى ^ت ر | |
| | | oruary 8, 2012 at 8:5 #5 was assisted byTe | | | A Resident Service Coordina | tor | , |
| | #2 into a sitting pos | ition and the facility's | Quality | | position was added on Febru | ary | 35 |
| | | (a Licensed Practical ation to the resident | | _ | 16, 2012 to be responsible fo | or | |
| , | spoon. Continued o | | | | scheduling with a primary fo | cus of . | F. A. S. S. |
| | | ically lifted the reside | ent and | | staffing. The staffing is | _ | 1731/24 (1744) |
| | placed the resident | onto the pea. | | .] | determined by the number of | | |
| • | Review of an Acuity | Discharge Planning | Report | | residents being serviced and | | : - ::::::::::::::::::::::::::::::::::: |
| [| dated December 9, February 7, 2012 re | 2011 provided by the | e ED on termined | | Individual care plan needs. | • | Barrier III |
| j | twenty-six residents | including Residents | #2 and | ł | Resident Service's Coordinat | | |
| | #5 required "Immed | | tinued | , | reports directly to the Reside | | |
| | review revealed the | tollowing: | • | | Service Director. The Reside Service Director will review a | | |
| | Resident #2: need | | | , | sample of the care plan's on | _ | 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1 |
| | Resident #5: Hosp Resident #6: Tota | | | ļ | per week for the next 6 wee | | المرافعة المرابية |
| | Resident #7: 104 | years old; hospice; to | otal care | ļ | ongoing as needed. | | |
| 1 | . Resident #8: Nor | n-ambulatory; total c | are | . [| Oligonia as decorrar | <u>.</u> | |
| 1 | Resident #9: Wo Resident #24: Tot | | ļ | | | _ | 77.30 |

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C-B. WING 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) iD COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY D 603 D 603 Continued From page 4 The Executive Director and Resident #25: Non-ambulatory Resident Services Director have a Resident #26: Non-amb (non ambulatory), two system of checking the staffing person transfer: - Hospice-Resident #27: Needs secure unit model to ensure it is sufficient to Resident #28: Total Care... meet the aculty needs of the Resident #29: Total Care... residents. Labor hours are Resident #30: Two person tranfer Resident #31: Confused: non-ambulatory reviewed Monday through Friday Resident #32: Total Care with Executive Director, Resident Resident #33: Blind; Total Care Service Coordinator and Resident Resident #34: Wanders: needs secure unit Resident #37: Total Care Service Director to ensure Resident #38: Confused; total care adequate staffing is utilized. This Resident #39: Non-ambulatory system is monitored weekly by reporting during the regional Review of a letter from the facility and dated operations call with the Regional January 18, 2012 revealed "...Notice of Discharge and Transfer...(Resident #39)...has needs that Director of Operations and Quality cannot be safely and effectively met in the Service Manager Community (assisted living facility)..." Corrective Action: Review of letters from the facility and dated January 19, 2012 revealed "... Notice of Discharge The level of care assessment and Transfer...(Residents #8, #24, #25, #26, #27, #28, #29, #30)...has needs that cannot be which is completed prior to move safely and effectively met in the Community..." in, after 30 days, every 6 months or upon a change of condition or Review of letters from the facility and dated January 20, 2012 revealed "...Notice of Discharge return from an alternative setting and Transfer...(Residents #34, #40-Resident #40 such as, hospital, rehab/skilled was not included on the facility provided Acuity. care or home, and labor hours will Discharge Planning report dated December 9, 2011)...Notice of Discharge and Transfer...has be reviewed by the Quality needs that cannot be safely and effectively met in **Assurance Committee consisting** the Community..." of the Executive Director, Resident Review of the facility's current census dated Services Director, Resident January 30, 2011 revealed eighteen of the residents identified by the facility in the report

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING - - GM TANK B, WING 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSG IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 603 D 603 Continued From page 5 Services Coordinator, Maintenance Director, Dining dated December 9, 2011 remained in the facility. Services Director, Business Office Coordinator and Healthy Lifestyles Interview with the Chief Operating Officer on January 31, 2012 at 9:00 a.m. in the ED's office Director, monthly. 4-10-12 revealed the facility had twenty-two current residents for whom the facility was unable to provide the required care and confirmed the facility had insufficient staff to meet the needs of the residents. C/O: #28393, #29126 D 609 1200-08-25-.06 (1)(b)3. Administration D 609 D609 (1) Each ACLF shall meet the following staffing Corrective action for residents and procedural standards: affected: - 198-5 230 (b) Policies and Procedures: The licensed nurse or shift 27.70.000 supervisor will contact the 3. An ACLF shall develop a written policy, plan or procedure concerning a subject and adhere to appropriate authorities, to include Its provisions whenever required to do so by the police if applicable, in the these rules. A licensee that violates its own policy event of an emergency requiring established as required by these rules and regulations also violates the rules and regulations such action. establishing the requirement. Resident #2 was discharged to a hospital on 12-24-2011. Resident #14 was discharged to a This Rule is not met as evidenced by: Behavioral Health Facility on 12-Based on medical record review, review of facility investigation documentation, review of 24-2011. ambulance service documentation, review of police investigation documentation, review of facility policy and Interview, the facility failed to notify the police and fully investigate an allegation of assault according to the facility's abuse policy for one resident (#2) of twenty residents

PRINTED: 03/12/2012 " FORM APPROVED

| DIVISION | of Health Care Fac | IIIIES | | | | DEAL D 175 CO | ID (CV |
|--------------------------|--|---|----------------------|---------------------------|---|------------------------|--|
| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIE | R/CLIA | (X2) MULTIF | PLE CONSTRUCTION | (X3) DATE SI COMPLE | |
| AND PLAN (| OF CORRECTION · | IDENTIFICATION NUM | VREK: | A. BUILDING | 3 | į č |) |
| | | TNPL53766 | | B. WING | | 03/0 | 1/2012 |
| NAME OF P | ROVIDER OR SUPPLIER | · | | | STATE, ZIP CODE | • | • |
| | FT OF TWIN HILLS | | 94 TWIN H MADISON | IILLS DRIVE , TN 37115 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE · | COMPLETE DATE |
| D 609 | Continued From pa | gge 6 | | D 609 | Other Residents that could potentially be affected: | | |
| | teliomen. | • | | | m of militarian design | J | |
| - | The findings includ | ed: | į | | Executive Director and Resid | | |
| . | Resident #2 was a | dmitted to the facility | on . | | Services Director In-serviced | | · · |
| | October 12, 2010 v | vith diagnoses includ | ling | | entire staff March 20, 21 ar | | |
| - | Dementia, Hyperte | nsion, and Depressio | n | : | 2012 on incident reporting, | | |
| | Medical record revi | lew of a Chart Note d | ated | | completion of the incident r | | 1000 |
| | December 24, 201 | 1 at 10:00 p.m. revea | | | and chain of command, tho | | AND WEST |
| . [| "discovered in ro | om by Care | | | investigation of alleged abu | • | The state of the s |
| | Attendantbleedin | g from nose, ear, mo swollen. (Resident # | um, and 2) stated | | including those incidents wh | | 11 - 12 A. |
| | that roommate (Re | sident #14) was tryin | g tọ kill | | require notification to the T | | |
| | (Resident #2) and | had beat (Resident# | 2) up. 📗 | | Department of Health, Adul | | وروح كالوجيد فراس |
| | it was bloody and b | at belonged to (Residual Proke into (in two)R | esident | | Protective Services and other | | 10000 |
| j | sent to ER (emerge | ency room)" Medica | al record | | authorities including the po | ice if | West and |
| | review of an undate revealed, "(Resider | ed, untimed Chart No nt #14) was question | ed by | | necessary. | ٠. | Sandary of the Salar |
| | (Medication Superv | /isor #2)stated that | (Resident | | Executive Director and Resid | ient | |
| Ţ | #14) did not hit (Re had hitself." | esident #2), that (Res | ident#2) | | Services Director In-serviced | l the | |
| | | | | | entire staff March 20, 21 an | d 22, | 22.2 |
| | Review of an Ambi | ulance Service Repot | t dated | | 2012 on those resident's tha | at may | interior |
| | December 24, 201 | 1 revealed a call was ambulance arrived o | received n the | | request a sitter service. We | | 1 - A-A |
| j | scene at 10:21 p.m | transported the res | sident at | | currently do not have any | | |
| | 10:39 p.m. and incl | luded "Chief Compl | aint: Fall | | resident's utilizing a sitter se | ervice | |
| | with Bieeding from | head" Continued re drawn through the o | evtew hlef | | at this time. The in-service | | - William |
|] | complaint and inclu | ided "(10:35 p.m.) l | Pulse 56 | | included that sitters will be | 11/201 | |
| | Blood Pressure 200 | 6/92Bleeding, facia | l trauma, | | required to have a backgrou | ınd | 100000000000000000000000000000000000000 |
| ļ | hand traumaPt (p | patient) was beaten b caneAOS (arrived | y on scene) | | check completed by the hiri | | |
| j | to find(Resident # | #2) sitting in facility w | /c | | agency, the abuse registry of | | |
| | (wheelchair)seve | re swelling to L side (| of face, | | drug screen and evidence of | f non- | The second section |
| | nose deformedL | (left) eye swollen, co side of facepupils | pinpoint | | communicable disease/ TB | ::: | |
| | and non reactive | abrasions to top side | of both | | screening. | . N. | |
| | _ | | | | | | U ON WELL TO THE |

Division of Health Care Facilities

Division of Health Care Facilities (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING_ 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES תו (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 609 Measures and systematic changes D 609 Continued From page 7 to prevent recurrence: hands ...transported...to (Hospital #1)..." Medical record review of an Emergency Room The Executive Director and Report (Hospital #1) dated December 24, 2011 Resident Services Director have revealed "...the patient was at ... assisted living facility ...where (Resident #2) was assaulted been in-serviced on the proper by...roommate...beaten about the face with a completion of an abuse cane...has dementia...ls a fall risk...chronic falls at investigation including notifying baseline. Therefore ...wears a helmet...helmet was apparently on..,when...actually beat...so hard the appropriate authorities by the that the cane broke...severe trauma to...face...left Quality Services Director, March auricular hematoma with small skin tear on the 19, 2012. superior portion of the auricle...large abrasion at...maxilla/inferior orbital region with a large skin tear and a moderate amount of swelling and **Executive Director and Resident** ecchymosis (brulsing)...0.5 cm (centimeter) skin Services Director in-serviced the tear over...nasal bridge...edematous nose with a entire staff March 20, 21 and 22. deformity, clotted nasal blood bllaterally...upper and lower lip edema with some 2012 on incident reporting, the abrasions...clotted blood present (in completion of the incident report mouth)...Both...hands show defensive and chain of command, thorough wounds...puncture wound on the dorsum of the right hand ...comminuted bilateral nasal bone investigation of alleged abuse, fractures and a large left facial including those incidents which ...hematoma...obviously in a severe amount of require notification to the TN pain with multiple fractures. I do not feel like (Resident #2) is safe to be discharged home with Department of Health, Adult concern for an obstructing Protective Services and other of...alrway...Disposition: (Hospital #2)..." authorities including the police if Medical record review of a History and Physical necessary. (Hospital #2) dated December 25, 2011 revealed ...was attacked by...roommate and hit in the face Executive Director and Resident several times with a cane...also sustained soft Services Director In-serviced the tissue damage to...right hand while trying to defend...self from the blows...bilateral nasal entire staff March 20, 21 and 22, fractures ...left periorbital hematoma with swollen 2012 on those resident's that may and tender nose as well as a laceration of the request a sitter service. We upper lip...CT (computed tomography)...comminuted bilateral nasal bone

| Division | of Health Care Faci | littes | | | | (X3) DATE SL | IDVEV |
|--------------------------|--|--|------------------------|---------------------------|---|----------------|--|
| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | R/CLIA | (X2) MULTIF | PLE CONSTRUCTION | COMPLE | TED | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NU | MBER: | A. BUILDING | · | , c | • |
| . • | | TNPL53766 | | B. WING | | 03/01 | /2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADI | DRESS, CITY, S | TATE, ZIP CODE | | |
| | FT OF TWIN HILLS | | 94 TWIN H MADISON | HILLS DRIVE , TN 37115 | · | | · · · · · · · · · · · · · · · · · · · |
| (X4) ID PREFIX TAG | /EACH DEFICIENC) | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL ! | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | DULD BE | (X5) COMPLETE DATE |
| D 609 | Continued From pa | | | D 609 | currently do not have any | | |
| | • | e paranasal left perio | orbital and | | resident's utilizing a sitter s | ervice | |
| - | left facial masticato | or space hematoma v | vith · | · | at this time. The in-service | | |
| | involvement of the | left messeter | | | included that sitters will be | |] ` |
| | muscleimpressio | n: 1. Blunt facial trau ult3. Lip laceration | ma status | | required to have a backgrou | und | |
| | post repair7. Den | nentia" | | · | check completed by the hir | ing | · |
| · | | lew of a Consultation | Panort | | agency, abuse registry chec | k, drug 🛒 | |
| | (Hospital #2) dated | December 25, 2011 | revealed | | screen and evidence of non | ı - | - marine |
| | "was transferred | to (Hospital #2) for | - | | communicable disease/ TB | | |
| | otolaryngology eva | luationDue toend dependent under the | stage care of | 1 | screening. | | |
| | caregiversWe will | Il ice left side offac | enext 48 |] : | N Saude Dimen | | and the state of t |
| | hoursinternal lip | laceration that was r | epaired in | [| The Resident Service Direct | e | |
| | several places with | nsuture after injection with a swelling of fa | on with 170: ce and | | Executive Director will inpu | | septimizari. |
| l | nose to resolve over | er the next 5-7 days : | and at that | | Incident report data into th | | 1 |
| | | or functional and cos | metic | | company online incident re | | |
| | deformity" | . , | | | system within 72 hours of a | | |
| | Medical record revi | iew of a Discharge S | ummary | | incident for tracking and tr | | 100 |
| | (Hospital #2) dictat | ed December 27, 20 ion at Discharge:co | i]] hmhletelv | | The Director of Compliance | | 11 21 21 21 |
| ł | alert and oriented t | oself and not to the | e place | | reviews this report monthly | у. | , |
| | and time, which is a dementia(spouse | probably related to o notified about the | hronic plan for | | Corrective Action: | | |
| | discharging, Hower | ver, the patient want never wanted to get | back to | | The incident reporting syst | em | - |
| | the previous one" | " Medical record revi | ew of a | į | tracking and trending sum | mary | 720 |
| | prescription signed | i by the physician res | ponsible | | will be reviewed by the Qu | ality 🧺 | · · · · · · · · · · · · · · · · · · · |
| | for the Discharge S | Summary and dated "Lortab 5/325 one or | two po | | Assurance Committee cons | sisting | |
| 1 | a6h pro pain (by m | outh every six hours | as | | of the Executive Director, F | Resident | |
| . | needed for pain)." | | | | Services Director, Resident | ; | 1 |
| | Review of facility in | vestigation docume | ntation | | Services Coordinator, | 23 | |
| | dated December 2- revealed "Time 1 Injury/Unusual Occ | 4, 2011 on January 3 0:00 p.mPrimary currence Possible He | ad Injury | | Maintenance Director, Din | ing :: | |
| ļ | Skin Breakdown Br | ruise Cuts/Scrapes | Was the | . . | | | <u> </u> |

| DIVISION | i di neallin Care Faci | mues | | | | | and the second |
|--------------------------|--|---|---|----------------------------|---|------------------------|--------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | | 1, , | PLE CONSTRUCTION | (X3) DATE SU COMPLE | TED |
| | • | TNPL53766 | | | | , , | , 1/2012 |
| NAME OF P | ROVIDER OR SUPPLIER | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| | OFT OF TWIN HILLS | • | 94 TWIN I MADISON | HILLS DRIVE I, TN 37115 | <u>:</u> | <u> </u> | · · · · · |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM/ | FULL | . ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AC DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE |
| D 609 | incident witnessed? Associate #2) Invest Resident was found mouth, Jaw appears thatroommate (RHospitalized? Yest Continued review re by Medication Super by the "General Materies of Police de documentation date revealed "Offense AssaultWeapon (Invested to the Police of Was called by an El technician)that(Invested to the Injuries of Informed that (Resident #14) up. (Invery angry and viole (Resident #2) with Injuries of the Injuries of Informed that Injuries of Inj | NoDiscovered by stigation Observation of in room bleeding freed to be swelling,states and was not be supported the report was revisor #2 and was not be a partment investigation of Abuservisor #2 and was not be a pescription: Aggram Dode: blunt objectEMT (emergency med Resident #2) had be a went out to (facility) are Associate #2) was defined to was a conficers were thered while doing room on the support of the consumption of the consumpt | s: om ear, ated oncane se: No" as signed ot signed on ii vated Dispatch ical en beatenspoke are checks mmon ot the e ecame g acilliy) and | D 609 | Services Director, Busines Coordinator and Healthy I Director, monthly. | | 4-10-12 |
| | officers went to the (hospital)(Medical manager on duty du officers went to the scene had been cle | de with the facility ur location after being a tion Supervisor #2) waring the incidentW incident location the eaned up by the center evealed Medication Seved. | at /as the /hen crime er staff" | v | • | | |
| 1 | 1, 2011 revealed " | y's Abuse Policy date Each resident has t able investigation in | he | | | : i [*] | |

GQB511

| <u>Division</u> | <u>of Health Care Fac</u> | littes | | | | | |
|--------------------------|--|---|---|----------------------------|---|--------------------------------|--------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (XI) PROVIDER/SUPPLIE IDENTIFICATION NUI | | 1 | LE CONSTRUCTION | | |
| NAME OF P | ROVIDER OR SUPPLIER | 1111 400100 | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| | FT OF TWIN HILLS | : | 94 TWIN I | HILLS DRIVE I, ȚN 37115 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X6) COMPLETE DATE |
| | to: Ensure the residence environment reporting and investigations of a comply will aw Definitions of or negligent that residence assault The environment of an inverse include assault The environment of an inverse include assault The environment of an inverse include All witnesses completed in as should be possible Report the facts (i.e., verballong on the nature and the incident (s) could be incident (s) could be incident (s) could be incident of any alleged assaution of any alleg | The purpose of this plant's right to a safe at. Provide a means of tigation alleged abustiff residents rights at Abuse:Any action, sults in bodily harmThe Executive Director estigation is warrantesObtain relevant infosThe process shall | and of e of a nd the deliberate may or will: ed after ormation be ment of pending aged d to report loe: the d on the: the oe notified very as a have | D 609 | | 2.00 | |
| | January 31, 2012 at revealed no knowle resident abuse or rein the past three mo | executive Director (Ell t 9;00 a.m. in the ED dge of an allegation esident-to-resident al onths; the ED stated ' we necessitated an in | 's office of tercation "If there | | | · ; | |
| | on January 31, 2012 office revealed no k resident abuse or re | hief Operating Office 2 at 9:00 a.m. in the I nowledge of an alleg esident-to-resident all enths. Interview with t | ED's ation of tercation | · . | | • | |

| Division | of Health Care Faci | lities | <u> </u> | | <u> </u> | 000 3475 01 | DVEV |
|--------------------------|---|--|--|---------------------------|---|------------------------|--------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM | RICLIA MBER: | A BUILDING | LE CONSTRUCTION | (X3) DATE SU COMPLE | LED |
| | | TNPL53766 | | B. WING | | 03/01 | /2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TATE, ZIP CODE | | |
| ELMCRO | FT OF TWIN HILLS | | 94 TWIN I MADISON | HILLS DRIVE , TN 37115 | | · | nun . |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | THE APPROPRIATE | DATE COMPLETE (X6) |
| D 609 | Continued From pa | nge 11 | | D 609 | | | |
| | was aware of the fa documentation date facility had made in | 2 at 10:00 a.m. reversality's investigation ed December 24, 20 aquiries regarding regraing the injuries to R 31, 2012. | 11 and the julatory | | • | | |
| | January 31, 2012 a revealed the reside change of roomma stated "It was obvidues (Resident #2). As a ownership (August | Quality Services Man at 10:47 a.m. in the E ent's family had reque ites for the resident a ous (Resident #14) h soon as the company 11, 2011) we had ass ent #2) was on list to | D's office ested a and she ad beaten assumed essed | | | | |
| | February 1, 2012 a revealed the facility who worked the ev 2011. Continued in from all staff who pother shifts on Decobtained and the in | Quality Service Mana at 1:10 p.m. in the ED y had statements from the rening/night of Decenterview revealed statements from the revided care to Resistember 24, 2011 had not the State Agency. | office of | | | | |
| | President of Resid Included the Execut Services Manager) p.m. in the Executi "We understand this point in time resigned and dated, lawyersno inform | w with the Senior Vicent Services (conferently Director and Qu) on February 1, 2012 ve Director's office reseverity of (the) situate statements from erjust statements taken attion that any care staggressive tendently | ence call ality 2 at 2:40 evealed ationAt apployees a by our taff aware | | | | |
| | February 1, 2012 a | e Associate (CA) #2 out 3:00 p.m. in the Exvealed CA #2 had no | ecutive | , | | | |
| Division of H | ealth Care Facilities | | | 6889 (3 | 3QB511 | If continuati | on sheet 12 of f |

en e de sete Conservação Conservação

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (XE) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE. REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) D 609 D 609 Continued From page 12 witnessed the beating of Resident #2 and included "...don't think I've been inserviced on abuse since I've been here...If saw resident to resident altercation report it stop it ...have not seen any of that since I've been here..." Continued interview revealed CA #2 had never seen Resident #2 hit anvone and CA #2 stated "...confused most all the time...December 24, 2011...in bed asleep about 7:30-8:00 p.m. Back again,...probably 9:45 (p.m.). Got to ... room. Chair against (the)door, (the) door was cracked. (Resident #2) was standing there. I asked what are you doing, I reached and moved (the) chair (Resident #2) standing there all bloody on the shirt, all over (resident's) face...on pants. Little blt of blood on doorway of (Resident #14's) room. (Resident #2) was covered with blood. I ran and got nurse (Medication Supervisor #2) (saw blood on doorway after got nurse). We sat (resident) in chair...bleeding from law, gobs out of nose, coming from mouth, blood from right ear. Majority (injuries) on right side. (Resident #14) was laying in the bed, didn't see any blood on (Resident #14), (Resident #14) was awake. Another caregiver (Medication Technician -MT#3) came and noticed a stick beside (Resident #14's) bed. He asked (Resident #14) did you hit (Resident #2) with this cane. (Resident #14) said no (Resident #2) broke it and I took it from (Resident #2) ...(MT #3) asked, 'Where's the other half of the cane?' and (Resident #14) said it was on the other side of the bed. There was blood on the end of the cane where you hold it. Didn't see any blood on end that was broken off but I didn't examine it. I took the cane and held it. I laid it on the med (medication) cart, both pieces. There was wood chips on the floor in (Resident #14's) room...(Resident #2) had pajama pants on with white tee-shirt. Gobs of blood on white tee-shirt. (I) saw no blood on (Resident #14's) bed, 911

Division of Health Care Facilities STATE FORM

GQB511



| Division | o <u>f Health Care Fac</u> | lities | | | | | |
|--------------------------|---|--|--|---------------------------|--------------------------------------|--|--------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | R/CLIA MBER: | A. BUILDIN | PLE CONSTRUCTION | (X3) DATE SU COMPLE | TED |
| | | TNPL53766 | | B. WING _ | | 03/0' | 1/2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | • | |
| ELMCRO | FT OF TWIN HILLS | | 94 TWIN I | HILLS DRIVE , TN 37115 | | · | , |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL 1 | ID PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY) | (X6) COMPLETE DATE |
| D 609 | Continued From pa | ge 13 | | D 609 | | | |
| | (Resident #14) "wh What did you do to #14) said I didn't do toself. There's no No evidence (Resid before supper (Resident #2 would ambulance man sa (Resident #14) did policepolice calle | ibulance came. They at happened to this run (Resident #2) and to anything. (Resident way possibledid it ient #2) had fallen ident #14) said 'I wis lident #16 jault following me id, 'he did not do this this You all need to d me at 1:30 a.m. afte what I saw. I don't | nan. (Resident #2) did it toself. That day th the hell The toself. call the | | | | |
| | p.m. In the ED's off witnessed the beat included "(Residen wandering and rem Continued interview attendant(Reside blood in (Resident a cane was under the visible between the | 3 on February 1, 20 ice revealed he had ing of Resident #2 art #2) had a history of oving (own) clothes a revealed, "notified in #2) was bleeding. #14's) room. One pied bed and other piece bed and dresserbi | not " " I by care I noticed ice of the was ood on | | | | |
| - | entrance of (Reside where cane was at room in wheelchair (Resident #14's) ro was broke offafte report. I called the a helmet on when I s bloody. Nose puncitAmbulance arriv'Dudewhat happe | ent #14's) room and in (Resident #2) was in Blood from entrance om and drops to whe infinding cane we may ambulance(Resident awleft ear mouth a ured had blood coming ed, asked (Resident ned'That day (Resident dent #14) and (Resident | from Ilving to to the tale the | | • | ر مدر م الكراف المراجع م | |
| - 1 | #2 on February 2, 2 | v with Medication Su 012 at 1:55 p.m. rev he beating of Reside | ealed she | | | · . | |

PRINTED: 03/12/2012 FORM APPROVED

| Division | of Health Care Faci | lities | | | | | 200 A 100 B |
|--------------------------|--|--|---|-------------------------------------|---|-------------------------------|---|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | R/CLIA MBER: | (X2) MULTI A. BUILDIN B. WING | PLE CONSTRUCTION G | (X3) DATE SI COMPLE . C | TED . |
| | | TNPL53766 | 0T0FFF 401 | DRECO CITY | STATE, ZIP CODE | | |
| | PROVIDER OR SUPPLIER OF TWIN HILLS | | 94 TWIN I | HILLS DRIVI | E . | | |
| (X4) ID PRÉFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | 10 PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDERICIENCY) | HOULD BE | (X6) COMPLETE DATE |
| D 609 | almost total carer annoying person. (' wayI went to room care attendanthad was trying to kill me notesI called the nurse thereThe p police. They had co I didn't call them. I o policeman told me considered as assa (was) in bed calm, of blood on (Reside brought it to my atte converse in full sen communicated in vi- | ful and she stated " no anger issues just in the type person to be made and I charted that in ambulance There we call the transition with me addn't see it as a criminose had been broke ault In room (Reside cool, collected. I did not be the the the the the the the the the th | ittle be in your e with id, 'He ras no call the about why be. The and ent #14) see drops #3) 4) could | D 609 | | | |
| | (RSD) on February Executive Director's unable to identify th #2 on December 24 | • | in the RSD was Resident | | | en de Historia | |
| | contracted sitter se 2:38 p.m. revealed service was assign evening of Decemb approximately 9:00 | p.m. | 2012 at the the | | | | \$ 10. j |
| - | (RSD) on February revealed the RSD has residents regarding December 24, 2011 | v with Police Detective | n. ny ent #2 on ve #1 on | | | • 8 | |
| | February 7, 2012 at | 10:55 a.m. revealed se. I can tell you that. | l "They | | | | <u> </u> |

| DIVISION | of Health Care Fac | nnes | | | | | |
|--------------------------|---|---|--|---------------------|--|------------|---------------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | | A 11816 | | | |
| 114147 00 0 | | TNPL53766 | STREET ADD | DESS CITY. | STATE, ZIP CODE | | • ; |
| | ROVIDER OR SUPPLIER OFT OF TWIN HILLS | | 94 TWIN I | HLLS DRIV | E | | ÷ |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL [| ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | ISHOULD BE | (X5) COMPLETE DATE |
| D 609 | until days latergo Stopper's tip regard called the police. Police had been cle officer they had the Complications (of) death" | They didn't mention to (anonymous) Crime (anonymous) Crime (ing the cane(Hospolice respond go to fee aned up. They didn't murder weapondiction of the contract of the co | iltal #1) acility. t tell the d autopsy. cause of | D 609 | | | |
| | 7, 2012 at 8:50 a.m revealed she did no and she stated "0 building would have policethink I got to room. I asked if we was no mess! did had not been in. I k get statement from | executive Director on in the marketing of the thick throw who called the process of the called the | fice te police out of the nt to the m. There keeping anI did on the | | | | |
| | not sign itdid not i know any residents before the newspap (Resident #15) the (Resident # 15 had Resident #2 before to the hospital acco referred to by the E confirmed the facilit | and I wrote it(CA anterview any resident were aware until the per releaseI learned day the paper came been to room and sathe resident was trained to the newspaped)" Continued interpretated to notify the palleged assault according. | ts. Didn't day day dabout out sw asported per story rview police and | | | rus. | |
| | 10:50 a.m. in the ma facility's sitter policy the front desk on an departure. Continue for Resident #2 on I | D on February 7, 20° arketing office reveal required a sitter to srival and sign out on dinterview revealed December 24, 2011 as required by facility | led the lgn in at the sitter had not | | | , | ह्मार कर है। इस स्टब्स कर है |

| | of Health Care Fac | 71005 | | \neg | | (X3) DATE SI | 1DVEY |
|--------------------------|---|--|--|----------------------------|---|---|---------------------------------------|
| | TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: | RICLIA | | LE CONSTRUCTION | COMPLE | TED . | |
| ANDPLAN | OF CORRECTION | IDENTIFICATION NO | MIDEK: | A BUILDING | | | |
| | | TNPL53766 | | 1 = | | 03/0 | 1/2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TATE, ZIP GODE | | |
| ELMORO | OFT OF TWIN HILLS | | | HILLS DRIVE I, TN 37115 | | | · · · · · · · · · · · · · · · · · · · |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL 1 | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY) | OULD BE | COMPLETE COMPLETE |
| D 609 | Interview with the E a.m. in Resident #2 ED spoke to Medic resident was beate she stated, "had took it to the med (Interview with the S Resident Services p.m. revealed the f Protective Services | ED on February 8, 20 I's former room reveration Supervisor #2 and on December 24, 20 I put cane in plastic barmedication) room" Senior Vice President on February 10, 201 acility had falled to not the alleged assarty had falled to imple | aled the after the 2011 and ag and tof 2 at 2:20 olify Adult, and | D 609 | | | |
| D 629 | utilize standard pre guidelines establisi Control and Prever transmission of infe communicable dise a hand hygiene pro 1. Use of alcoholnon-antimicrobial of | ts employees shall a cautions in accordar ned by the Centers for the Centers f | nce with or Disease enting erence to clude: use of and water f hands | D 629 | Corrective action for reside affected: The facility will use gloves a follow hand hygiene for resilent and 18. Medication Technician #1 will use proper hygiene. Other Residents that could potentially be affected: Hand sanitizers were mount the walls throughout the factor proper hygiene for resident. | nd idents er hand ted on cility | |

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING_ 03/01/2012 TNPL53768 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) (D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) and visitors. Housekeepers have a D 629 D 629 Continued From page 17 schedule for ensuring they are failed to use gloves and adhere to a hand hyglene kept full. Housekeepers also have program for two residents (#17, #18) of twenty a schedule for ensuring soap and residents reviewed. hand towels are available in The findings included: resident apartments. Review of facility policy titled "Employee Hand Washing" dated August 1, 2011 revealed Measures and systematic changes "...Policy: Employees must wash hands under the to prevent recurrence: following circumstances:...After blowing nose, coughing, or sneezing...Before and after The Housekeeping/Maintenance preparing or serving meals, drinks...Before and Director will check all soap after having direct contact with residents...After removing gloves, which should be worn as a dispensers and hand sanitizer standard precaution when in direct contact dispensers weekly to ensure they with...resident equipment...etc...The community are adequately filled. (facility) should provide adequate warm running water, soap, paper towels in hand washing areas. If there is no hand washing facilities or supplies Staff was in-serviced by the available...should make available to the employee **Executive Director and Resident** waterless hand washing supplies to be used Services Director on March 20, 21 according to the manufacturer's recommenations. The employee should wash hands with soap and and 22, 2012 to include proper water as soon as feasible..." hand hygiene according to the facility policy. Hand Washing signs Observation on February 1, 2012 from 11:25 a.m. to 11:35 a.m. revealed Medicine Technician (Med are posted in the kitchen and in Tech) #1 coughed into her ungloved hands, employee areas, instructing touched the notebook of Medication employees of the necessity and Administration Records, and placed a bottle of medication into the medication cart. Continued proper method of washing hands. observation revealed Med Tech #1 placed the medication cart into the elevator, pressed the The Resident Services Director will elevator button for the first floor, coughed into the observe proper hand hygiene one the left ungloved hand, coughed into the right time per week for six weeks and ungloved hand, prepared medication, poured water from a pitcher into a cup, and entered ongoing as needed. This will be Resident #17's room without washing her hands. recorded on a spreadsheet to Continued observation revealed the Med Tech #1 held the medication cards, touched both of track compliance.

Division of Health Care Facilities

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 03/01/2012 TNPL63766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE ELMCROFT OF TWIN HILLS MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** D 629 D 629 Continued From page 18 Corrective Action: Resident #17's hands and assisted the resident The spreadsheet for tracking hand to push the medication into a cup. Continued observation revealed Med Tech #1 returned to hygiene will be reviewed by the the medication cart and did not wash her hands. **Quality Assurance Committee** Continued observation revealed Med Tech #1 consisting of the Executive coughed into her right ungloved hand, turned Director, Resident Services pages in the Medication Administration Records, Director, Resident Services obtained a bottle of medication and shook it, opened the narcotic drawer and obtained a Coordinator, Maintenance medication card. Continued observation revealed Director, Dining Services Director, Med Tech #1 poured water from the pitcher into a **Business Office Coordinator and** cup, entered the room of Resident #18, poured liquid medication into a cup, and assisted the Healthy Lifestyles Director, resident to take the medication. Continued 4-10-12 monthly. observation revealed Med Tech #1 returned to the medication cart after assisting Resident #18 and did not wash her hands. Interview with Med Tech #1 on February 1, 2012 at 11:35 a.m. in the corridor next to Resident #18's room revealed the med tech was unaware of any unacceptable practice during the observation. Continued interview revealed the practice was to cough into her shirt, and Med Tech #1 stated "...I ran out of gloves while ago. Most of the time I wash hands between patients and have hand sanitizer to help out...no sanitizer right now..." Continued interview revealed the med tech was aware not washing the hands and/or not using gloves could spread infection. Interview with the Quality Services Manager on February 10, 2012 at 1:07 p.m. in the marketing office confirmed the facility falled to utilize standard precautions including a hand hygiene program for Residents #17 and #18 on February 1, 2012. C/O: #28393

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 8. WING 03/01/2012 TNPL53768 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) D713 D 713 1200-08-25-.07 (7)(a)1. Services Provided Corrective action for residents (7) An ACLF shall provide personal services as affected: follows: Residents number 2, 14 and 5 (a) Each ACLF shall provide each resident with have been discharged from the at least the following personal services: facility. Resident #20 will be and March Protective care: provided protective care according . to the facility abuse policy by inservice training the staff. This was completed on March 20, 21, and 22. 2012 to include verbal This Rule is not met as evidenced by: instruction and to provide Based on medical record review, review of facility understanding of the different investigation documentation, review of police investigation documentation, review of facility types of abuse. The policy has policy, review of a facility staffing schedule, been posted by the time clock for review of an Aculty Discharge Planning report easy access/review. Staff will be and interview, the facility falled to provide protective care for three residents (#2, #5, #20) of in-serviced on abuse upon hire, twenty residents reviewed. and annually. The findings included: Other Residents that could Resident #2 was admitted to the facility on . potentially be affected: October 12, 2010 with diagnoses including **Executive Director and Resident** Dementia, Hypertension, and Depression. Services Director In-serviced the Medical record review of a Chart Note dated entire staff, March 20, 21 and 22, December 24, 2011 at 10:00 p.m. revealed "...discovered in room by Care 2012 on responding appropriately Attendant...bleeding from nose, ear, mouth, and in a crisis situation. This was jaw appeared to be swollen. (Resident #2) stated accomplished through verbal that roommate (Resident #14) was trying to kill (Resident #2) and had beat (Resident #2) up. instruction and examples of Cane was found that belonged to (Resident #14) situations that would be it was bloody and broke into (in two)...Resident sent to ER (emergency room)..." Medical record determined as a crisis situation.

Division of Health Care Facilities

| <u>Division</u> | of Health Care Fac | lities | | 1 | | (X3) DATE SU | JRVFY |
|--------------------------|--|--|------------------------------------|--------------------------|--|---------------------------------------|--|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIE | R/CLIA | .1 * * | E CONSTRUCTION | COMPLE | TED |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUI | MOEK! | A BUILDING | | C | |
| | | TNPL53766 | | B. WING | | 03/0 | 1/2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, ST. | ATE, ZIP CODE | | • |
| | FT OF TWIN HILLS | | 94 TWIN H MADISON | HLLS DRIVE , TN 37115 | | <u>-</u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | 'FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO GROSS-REFERENCED TO THE APP DEFICIENCY) | OLD RE | (X6) COMPLETE DATE |
| D 713 | Continued From pa | age 20 | | D 713 | The Maintenance Director | | |
| | , | ed, untimed Chart No | ofe | | assessed all door locks on M | arch | |
| | revealed, "(Reside | nt#14) was question | ed by | | 29, 2012 to ensure they are | in | 1 |
| | (Medication Super #14) did not hit (Re | visor #2)stated that esident #2), that (Res | t (Resident | | proper working order. | • | |
| : | had hitself." | • | | | Measures and systematic cl | anges | |
| | Medical record rev Report (Hospital# | lew of an Emergency 1) dated December 2 | y Room 24, 2011 | | to prevent recurrence: | e e e e e e e e e e e e e e e e e e e | ABRIT S |
| | revealed "the pa | tient was atassisted | d living | | Executive Director and Resid | lent | " |
| | facilitywhere (Resident #2) was assaulte byroommatebeaten about the face with canehas dementiaactually beatso ha | | ssaulted | | Services Director In-serviced | | , |
| | | | hard that | | entire staff, March 20, 21 an | | , |
| | the cane broke so | evere trauma tofac | trauma tofaceleft 2012 on respondi | | 2012 on responding approp | | 2000 |
| | auricular hematom | ia with small skin tea The auticle—large ab | | in a crisis situation. | | | |
| · | atmaxilla/inferior | orbital region with a | large skin | | | _ | 1. ET 25 E. |
| | tear and a modera | ite amount of swelling | g and | | As per the standards, a men | nber of | |
| | l ecchymosis (bruisi | ing)0.5 cm (centimindgeedematous no | eter) skin ose with a | | management will see every | | |
| | deformity, clotted | nasal blood bliaterally | yupper | 1 | resident daily. | | |
| | and lower lip eden | na with some | | .] | The Maintenance Director v | vill do | 1000 |
| | abrasionsclotted | blood present (In nds show defensive | | .] | | | |
| | woundspuncture | wound on the dorsu | m of the | | preventative maintenance of | | j. |
| : | right handcomm | ninuted bilateral nasa | ll bone | | locks monthly to ensure the | y are | |
| | fractures and a lar | ge left facial lously in a severe am | nount of | | in proper working order. | | |
| | pain with multiple | fractures. I do not fee | el like | | Staff has been in-serviced b | y the | |
| | (Resident #2) is sa | afe to be discharged | home with | | Executive Director, March 9 | | |
| | concern for an obs | structing sition: (Hospital #2) | H | 1 | on reporting any physical pl | | A STATE OF THE PARTY OF THE PAR |
| | - | | | ' | issues to the Maintenance | | |
| | Medical record rev | iew of a History and | Physical |] [| Director via the work order | form | |
| | (Hospital #2) dated | d December 25, 201 yroommate and hit | In the face | | and via telephone in the ev | | - Paradelani |
| | several times with | a canealso sustain | ned soft | | an emergency. If unable to | | · · · · · · · · · · · · · · · · · · · |
| , | tissue damage to | right hand while tryii | ng to | | the Maintenance Director, | | 1 3 4 4 mg |
| | defendself from | the blowsbilateral r iorbital hematoma w | าสรสเ ith swollen | ' | staff has been instructed to | | |
| | and tender nose a | s well as a laceration | of the | | STOLL HOW DOWN HISEL MANNEY | | |

| <u>Division</u> | of Health Care Fac | llitles | | | | NAL BATE BU | DVEV: |
|--------------------------|--|--|---|---|---|-------------------------|--------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE | R/CLIA MBER [‡] ; | A. BUILDING | | (X3) DATE SU COMPLET | red ; |
| . | • | TNPL53766 | | B. WING | | 03/01 | /2012 |
| | ROVIDER OR SUPPLIER | | 94 TWIN H | RESS, CITY, ST HILLS DRIVE , TN 37115 | ATE, ZIP CODE | | • |
| (X4) ID PREFIX TAG | SUMMARY STA | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA | S FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPLICATION OF CORRECT (PROVIDER CORRECT) | ULU BE I | (X5) COMPLETE DATE |
| D713 | fracturesextensive left facial masticate involvement of the muscleImpression secondary to assar post repair7. Der Medical record revelogital (Hospital #2) dictar revealed "Condit alert and oriented and time, which is dementia(spoused discharging. Howe another facility and the previous one Review of facility in dated December 2 revealed "Time 1 Injury/Unusual Oct Skin Breakdown B incident witnessed Associate #2) Inversed Resident was foun mouth, jaw appear thatroommate (FHospitalized? Ye Continued review of by Medication Supthe "General Mana Review of police dedocumentation dat revealed "Offens AssaultWeapon was called by an E | inputed infinited bilateral nasive paranasal left period space hematoma vileft messeter on: 1. Blunt facial trauvilt3. Lip laceration imentia" If the of a Discharge Sted December 27, 20 it is at Discharge:co toself and not to the probably related to cle)notified about the ever, the patient wants in ever wanted to get a never wanted to be swellingst and not singer." Per a not singer." Per a not singer." Per a not singer." Per a not singer." | orbital and with ma status ummary 11 ompletely place hronic plan for s to be in back to otation 81, 2012 and injury Was the (Care as: oom ear, ated hcane se: No" as signed igned by on 11 vated Dispatch lical | D 713 | the chain of command for notifying the appropriate management staff. Corrective Action: The facility abuse policy and protocol for reporting, along the system for physical plan maintenance issues that need immediate attention will be reviewed by the Quality Ass Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Business Coordinator and Healthy Lift Director, monthly. | g with t/ ed urance t | 4-10-12 |
| · | technician)that | (Resident #2) had be | en deaten | 1 | | | <u>-</u> |

If continuation sheet 22 of

| Division | of Health Care Fac | lities | , <u>.</u> | · | | | LIGHTEY. |
|--------------------------|---|---|--|---------------------------|---|--------------------------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIE | R/CLIA | (X2) MULTIP | LE CONSTRUCTION | (X3) DATE SI COMPLE | ETED , |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUM | AREK: | A. BUILDING | | | ; |
| | | TNPL53766 | | B. WING | | 03/0 | 1/2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | _ | | TATE, ZIP CODE | • | İ |
| ELMCRO | FT OF TWIN HILLS | | 94 TWIN H MADISON | IILLS DRIVE , TN 37115 | | | <u> </u> |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL [| ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY | ON SHOULD BE HE APPROPRIATE | COMPLETE DATE |
| D 713 | Continued From pa | age 22 | | D 713 | | | |
| | up byroommatewent out to (facility)spoke with personnel(Care Associate #2) was the caretaker who found (Resident #2)" | | | | | | |
| | 1, 2011 revealed " to: Ensure the residuate secure environment | ty's Abuse Policy dat The purpose of this dent's right to a safe htDefinitions of Abu or negligent that resu Includeassault" | s policy is and ise:Any | | | | |
| | the Resident Care February 1, 2012 a Director's office rev #2, Care Associate | ing schedule and inte Coordinator (RSD) o at 1:48 p.m. in the Ex vealed Medication St a (CA)#2, CA #5 and e scheduled to work ecember 24, 2011. | n ecutive ipervisor Medical | | | · · . | 3- |
| | 11:25 a.m. in the n assignment on the beaten included se residents. Continue caregivers staffed | #2 on February 9, 20 narketing office revea evening Resident #2 even totally depender ed interview revealed the facility on Decem vent off duty at 8:00 p | aled her 2 was nt I three nber 24, | | | | TO SECURE |
| | January 31, 2012 a revealed no knowle | Executive Director (E at 9:00 a.m. in the Et edge of an allegation resident-to-resident a conths. | of office | | | | |
| . , | on January 31, 201 office revealed no | Chief Operating Offic 12 at 9:00 a.m. in the knowledge of an alle esident-to-resident a onths. | ED's . gation of | | | | |
| | Interview with the | Quality Services Man | ager on | | | | |

GQB511

| PREFIX TAG TAG Continued From page 23 January 31, 2012 at 10:47 a.m. in the ED's office revealed the resident's family had requested a change of roomates for the resident's (unspecified date) and she stated "It was obvious (Resident #14) had beaten (Resident #2). As soon as the company assumed ownership (August 1, 2011) we had assessed everyone (Resident #2) awas on list to move out." Interview with CA #2 on February 1, 2012 at 3:00 p.m. in the Executive Director's office revealed CA #2 had not witnessed the beating of Resident #2, and included "don't think I've been inserviced on abuse since I've been here" Conflued interview revealed the resident was confused, and CA #2 stated, "confused most all the time. December 24, 2011in bed asleep about 7:30-8:00 p.m. Back againprobably 9:45 (p.m.). Cottoroom. Chair against (the)door, (the) door was cracked. (Resident #2) was standing there, I asked what are you doing. I reached and moved (the) chair (Resident #2) standing there all bloody on the shirt, all over (resident) shoreon pants. Little bit of blood on doorway after got nurse. We sat (resident) in chairbleeding from jaw, gobs out of nose, coming from mouth, blood from right ear. Majortly (injures) on right side. (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was awake. Another caregiver (Medication Technicalan -M#3) came and noticed a sitck beside (Resident #14) side on (Resident #14) bid you hit (Resident #12) with this came. (Resident #14) side on (Resident #12) broke it and I took it from (Resident #12) broke it and I took it from (Resident | <u>Division</u> | of Health Care Fac | ilties | | | | · | OW DATE OU | DVEV |
|--|-----------------|---|--|---|--------------|-----------------------------|------------------------------------|----------------|--------------------------|
| INPLISTED INPUT STATE, IPP DODE 4 TWIN HILLS DRIVE INPUT INPLISTED INPUT INP | | | | | A BUILDIN | | · | COMPLE | TED ·- |
| ELMCROFT OF TWIN HILLS SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST SEPRECEDED BY FULL TAGE | | | TNPL53766 | | _ | | | 03/01 | /2012 |
| ELMOROFT OF TWIN HILLS SUMMARY STATEMENT OF DEFICIENCIES PRIETIX TAG D713 Continued From page 23 January 31, 2012 at 10:47 a.m. in the ED's office revealed the resident's family had requested a change of roommates for the resident (unspecified date) and she stated "the was obvious (Resident #14) had beaten (Resident #2). As soon as the company assumed ownership (August 1, 2011) we had assessed everyone (Resident #2) was on list to move out." Interview with CA #2 on February 1, 2012 at 3:00 p.m. in the Executive Director's office revealed CA #2, and included "don't think I've been inserviced on abuse since I've been hereI' saw resident to resident aftercation report it stop ithave not seen any of that since I've been here" Conflued interview revealed the resident was confused, and CA #2 stated, "confused most all the time. December 24, 2011in bed asleep about 7:30-8:00 p.m. Back agains. (the)door, (the) door was cracked. (Resident #2) was standing there. I asked what are you doing. I reached and moved (the) chair (Resident #2) was covered with blood, I ran and got nurse (Medication Supervisor #2) (sew blood on doorway after got nurse). Was staffed there. Majority (injuries) on right side. (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was awake. Another caregiver (Medication Technical -M1#3) came and noticed a sitck beside (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was laying in the seed (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was laying in the seed (Resident #14) was laying in the seed (Resident #14) was laying in the seed (Resident #14) was laying in the seed (Resident #14) was laying in the seed (Resident #14) was laying in the seed (Resident #14) was laying in the seed (Resident #14) was laying in the seed (Resident #14) was laying in the seed (Resident #14) was laying in the seed (Resident #14) was laying in the seed (Resident #14) was laying in the seed (Resident #14) was laying | NAME OF P | ROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, | STATE, ZIP CODE | • • | | , |
| PREFIX TAB D 713 Continued From page 23 January 31, 2012 at 10:47 a.m. in the ED's office revealed the resident's family had requested a change of roommates for the resident (unspecified dale) and she stated "It was obvious (Resident #14) had beaten (Resident #2). As soon as the company assumed ownership (August 1, 2011) we had assessed everyone (Resident #2) was on list to move out." Interview with CA #2 on February 1, 2012 at 3:00 p.m. in the Executive Director's office revealed CA #2 had not witnessed the beating of Resident #2, and included "don't think I've been inserviced on abuse since I've been here" Saw resident atteraction report it stop it have not seen any of that since I've been here" Continued interview revealed the resident was confused, and CA #2 stated, "confused most all the time December 24, 2011 in bed asleep about 7:30-8:00 p.m. Back again probably 9:45 (p.m.). Got to norm. Chair against (the)door, (the) door was cracked. (Resident #2) was standing there, I asked what are yout doing. I reached and moved (the) chair (Resident #2) was overed with blood, I ran and got nurse (Medication Supervisor #2) (saw blood on doorway after got nurse). We sat (resident) in chair bleeding from jaw, gots out of nose, coming from mouth, blood from right ear. Majotty (injuries) on right side. (Resident #14) was awake. Another caregiver (Medication Technical -M1#3) came and noticed a stick besider (Resident #4) come and noticed a stick besider (Resident #4) came and noticed a stick besider (Resident #4) came and noticed a stick besider (Resident #4) side (Resident #4) came and noticed a stick besident #4) came and noticed a stick besider (Resident #4) side (Resident #4) came and noticed a stick besider (Resident #4) side (Resident #4) came and noticed a stick besider (Resident #4) side (Resident #4) came and noticed a stick besider (Resident #4) side (Resident #4) came and noticed a stick beside (Resident #4) side (Resident #4) came and noticed a stick beside (Resident #4) | ELMCRO | FT OF TWIN HILLS | | | | | | | |
| January 31, 2012 at 10:47 a.m. in the ED's office revealed the resident's family had requested a change of roommates for the resident (unspecified date) and she stated "It was obvious (Resident #14) had beaten (Resident #2). As soon as the company assumed ownership (August 1, 2011) we had assessed everyone (Resident #2) was on list to move out." Interview with CA #2 on February 1, 2012 at 3:00 p.m. in the Executive Director's office revealed CA #2 had not witnessed the beating of Resident #2, and included "don't think I've been inserviced on abuse since I've been here If saw resident to resident altercation report it stop ithave not seen any of that since I've been here I' Continued interview revealed the resident was confused, and CA #2 stated, "confused most all the time. December 24, 2011in bed asleep about 7:30-8:00 p.m. Back againprobably 9:45 (p.m.). Got toroom. Chair against (the)door, (the) door was cracked. (Resident #2) was standing there. I asked what are you doing. I reached and moved (the) chair (Resident #2) was overed with blood. I ran and got nurse (Medication Supervisor #2) (saw blood on doorway after got nurse). We sat (resident) in chairbleeding from law, gobs out of nose, coming from mouth, blood from right ear. Majority (injuries) on right side. (Resident #14) was laying in the bed, didn't see any blood on Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was laying in the bed, didn't see any blood on (Resident #14) was laying in the bed, didn't s | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY | FULL. | PREFIX | (EACH CORRECT CROSS-REFEREN | TIVE ACTION SHO CED TO THE APPR | ULD BE . | (X5) COMPLETE DATE |
| #2) with this cane. (Resident #14) said no (Resident #2) broke it and I took it from (Resident It continuation sheet 24 | Ð 713 | January 31, 2012 a revealed the reside change of roomma (unspecified date) (Resident #14) had soon as the compa (August 1, 2011) w (Resident #2) was interview with CA # p.m. in the Executi CA #2 had not with #2, and included ". inserviced on abus resident to residenthave not seen an here" Confinued was confused, and most all the time! asieep about 7:30-againprobably 9: against (the)door, (Resident #2) was are you doing. I rea (Resident #2) was got nurse (Medication doorway after got coming from mouth (injuries) on right si in the bed, didn't se #14). (Resident #14 caregiver (Medicatiand noticed a stick | at 10:47 a.m. in the Eart's family had requestes for the resident and she stated "It was beaten (Resident #2 any assumed owners) the had assessed ever on list to move out." #2 on February 1, 20 are Director's office resident beating of a contitudent for think I've been here to altercation report it is a stated and moved (the company). Got toroo (the) door was cracked the death of the covered with blood. I don't think there all bloody of the covered with blood. I don't faceon pants by of (Resident #14's) covered with blood. I don Supervisor #2) (so the covered with blood. I don't covered with blood. I don | sted a s obvious s). As hip yone 12 at 3:00 evealed Resident eenIf saw stop it een e resident fused in bed om. Chair ed, ed what e) chair on the s. Little bit room. ran and aw blood sident) in ese, r. Majority eas laying ident er 8) came 4's) bed. | D 713 | | | and page | |
| | | #2) with this cane, (| (Resident #14) said r | 10 | | - | · | | 474 |
| | | | | | 6899 (| GQB511 | | If continuatio | n sheet 24 of 6 |

| <u>Division</u> | of Health Care Fac | ndes | | Ţ | | (X3) DATE SU | RVEY - |
|--|--|---|--|-------------------------|---|------------------------------|--------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUI IDENTIFICATIO | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | RVCLIA MBER: | (X2) MULTIP | LE CONSTRUCTION | COMPLE | TED |
| • | | F1101 50755 | · | B. WING | | | /2012 |
| | DOLEDED OD CHER IER | TNPL63766 | STREET ADD | RESS, CITY, S | TATE, ZIP CODE | a a | |
| | ROVIDER OR SUPPLIER OF TWIN HILLS | | 94 TWIN F | IILLS DRIVE TN 37115 | | | · |
| (X4) ID PREFIX TAG | SUMMARY ST/ | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | \$ FULL | .ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| D 713 | Continued From particles with a cane? and (Resolvent and the cane where blood on end that was wood chips or room (Resident and was wood chips or room (Resident and was called. The and (Resident and you do to an end the cane) was called. The and (Resident and you do to an end to a | age 24 ed, 'Where's the other esident #14) said it was ed. There was blood you hold it. Didn't see was broken off but I con he cane and held it. I con) cart, both pieces. In the floor in (Resident 2) had pajama pants be of blood on white In (Resident #14's) be mulance came. The hat happened to this on (Resident #2) and to anything. (Resident o way possibledid it dent #2) had fallen sident #14) said 'I wis d) quit following me #3 on February 1, 20 ffice revealed he had ting of Resident #2 a ht #2) had a history or noving (own) clothes following (Resident #3 d quit following me ew with Medication Si 2012 at 1:55 p.m. ret the beating of Resid orgetful and she state total careno anger | r half of as on the on the end of any sidn't laid it on There on with tee-shirt. I wasked man. (Resident t #2) did it it toself. That day is the heli wasked man. (That day is and the heli wasked man. That day is and the heli wasked man. That day is and the heli wasked is an and the heli wasked is an an an and the heli wasked is an an an an an an an an an an an an an | D 713 | DEFIGIENCY | | |
| | little annoying pers your way! went to with care attendan 'He was trying to k notes! called the | son. (The) type person or roomwas standing the control of the c | n to be in g there esaid, hat in the was no t call the | | | | |

| Division | of Health Care Fac | <u>Illties</u> | | | | | | 2.2.3 |
|--------------------------|--|---|--|---------------------------------------|-----------------|---|----------------------------|--|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | R/CLIA MBER: | (X2) MULTI A. BUILDIN B. WING _ | | | | SURVEY C C /01/2012 |
| | | TNPL53766 | CTOSST AD | npess city | STATE, ZIP CODE | | | • |
| [| ROVIDER OR SUPPLIER OFT OF TWIN HILLS | ! | 94 TWIN | HILLS DRIVI I, TN 37115 | E | | | - |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | (FACH COR | ER'S PLAN OF CO RECTIVE ACTION RENCED TO THE DEFICIENCY) | N SHOULD BE APPROPRIATE | COMPLETE DATE |
| D 713 | policeman told me considered as assa (was) in bed calm, of blood on (Reside brought it to my attraction to my attraction for the communicated in volume to the communicated in volume to the communicated in volume to the communicated in volume to the communicated in volume to the communicated in volume to the communicated in volume to the communicated in volume to the company of t | didn't see it as a crim nose had been broke autin room (Reside cool, collected. I did ent #14's) floor. (MT entlon(Resident #1 entlon(Resident #1 entlon(Resident #1 entlon) w with the manager of y 2, 2012 at 2:35 p.m. ployed by the servicent #2 on the evening 1 until approximately executive Director (Et 2:48 p.m. revealed as registry or backgresident's sitter. w with Police Detectif t 10:55 a.m. revealed to 1 can tell you that They didn't mention to (anonymous) Crime ting the cane(Hosping the cane(| e and ent #14) see drops #3) 4) could 2) of a sitter n. ee was y of 9:00 p.m. D) on the facility ound "They the cane elegated itself icer they cause of February fice ye police out of | D713 | | | | |
| | Interview with the E | view any residents D on February 7, 20 arketing office revea | 12 at | ' | | · · · · · | · | The state of the s |

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: C A. BUILDING B. WING 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37115 ELMCROFT OF TWIN HILLS PROVIDER'S PLAN OF CORRECTION · (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) TAG D 713 Continued From page 26 D 713 sitter for Resident #2 on December 24, 2011 had not signed in on the sign-in sheet as required by facility policy. Review of the staffing schedule and interview with the Resident Care Coordinator (RSD) on February 1, 2012 at 1:48 p.m. In the Executive Director's office revealed Medication Supervisor #2, Care Associate #2, Care Associate #5, and Medical Technician #3 were scheduled to work the evening shift on December 24, 2011. Interview with CA #2 on February 9, 2012 at 11:25 a.m. in the marketing office revealed her assignment on the evening Resident #2 was beaten included seven totally dependent residents. Continued interview revealed three caregivers staffed the facility on December 24, 2011 after Care Associate #5 went off duty at 8:00 p.m. Interview with the facility's Quality Services Manager (QSM) on January 31, 2012 at 10:47 a.m. in the Executive Director's office revealed the resident's family had requested a change of roommates for the resident and confirmed the facility had falled to provide protective care for Resident #2 on December 24, 2011. The QSM stated "...It was obvious (Resident#14) had beaten (Resident #2)..." Resident #5 was admitted to the facility on September 11, 2009 with diagnoses including Pick's Disease. Review of an Acuity Discharge Planning report dated December 9, 2011 revealed, "...total care..."

Division of Health Care Facilities

| Division | of Health Care Fac | ilities | . | | | | |
|--------------------------|------------------------------------|--|---------------------|---------------------|--|--------------------------------|--|
| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIE | | (X2) MULTIF | LE CONSTRUCTION | (X3) DATE SU COMPLE | |
| ANDPLAN | OF CORRECTION | IDENTIFICATION NU | MIDEIL | A. BUILDING | 9 | | |
| | | TNPL53768 | | B. WING | | 03/0 | 1/2012 |
|) | ROVIDER OR SUPPLIER | 1141. 2331 00 | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| | | • | 94 TWIN | HILLS DRIVE | | • | |
| ELMCRO | OFT OF TWIN HILLS | <u> </u> | MADISON | , TN 37115 | | OPPECTION | (75) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE IE APPROPRIATE | COMPLETE DATE |
| D 713 | Continued From pa | age 27 | | D 713 | | | |
| | Medical record revi | iew of a Chart Note o | lated | | | | 1 . |
| | September 7, 2011 | revealed "was fou | ind on | | , | | : |
| | floorhitheadn | o redness or bruising |]" | | | | |
| | Medical record rev | iew of Chart Notes d | ated | | , | | |
| | December 11, 201 | 1, revealed, "Took to ident slid out of chair | end was | • | | • | |
| | on floorgash on i | eft side of headto | and nao | | | | |
| | hospitalreturned, | spoke with Dr. (doc | or) stated | | | | [|
| | he put staples in | head" | | | | | |
| | Madical capand ray | iew of an Emergency | , Providar | 1 | | | |
| } | Report dated Dece | ember 11, 2011 reve | aled "fell | · | | • | |
| | out of wheelchair | .1.5 cm (centimeter) | lac | | | | 1 |
| | (laceration)non-a | imbulatory at | | | | | } |
| | baselinenon-com baselinestapled | | | | | • | ' |
| | Daseillieslapieu | •• | | | | | 20-123-0 |
| | Observation on Fe | bruary 8, 2012 at 8:5 | 8 a.m. | | | | |
| | revealed Medical T | echnician (MT)#2 | assisted | | | • | |
| | the resident to and | held the resident in a facility's Quality Se | an upngn. rvices | | · | | sh. worter |
| | Manager (License | d Practical Nurse) ad | ministered | Ì | | • .• | |
| | medication to the r | esident, Continued o | bservation | i | į, | | |
| | revealed MT #2 ph | ysically lifted the res | ident and | } | | | -Senten Senten |
| | placed the residen | t onto the bea. | | | | | |
| 1 | l Review of an Acuit | y Discharge Plannin | Report | • | | | Annual State of the State of th |
| | dated December 9 | , 2011 revealed, "t | otal | <u> </u> | | | , , , , |
| | care" | | | | | | |
| | Intonious with the I | ED on February 1, 20 | 112 at 2:10 | 1 | ; | | .] |
| | n m revealed the t | acility determined or | 1 | | ĺ | | 4 |
| | December 9, 2011 | the resident's needs | could not | | , | • | 100 |
| | be met in the facilit | ty. Continued intervie | W |] | | • | |
| | confirmed the facili | ity failed to provide p t5 on December 11, | rotective 2011 | 1 | | | [|
| | care for Resident # | M OII DECAMBAL LIT | EVIII | | | • | |
| | | | | | 1 | | |
| | • | | | | | | 100000 |
| | | | | | | | 1 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - |

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 03/01/2012 TNPL53768 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE ELMCROFT OF TWIN HILLS MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 713 Continued From page 28 D 713 Resident #20 was admitted to the facility on February 1, 2011 with diagnoses including Chronic Obstructive Pulmonary Disease and Pacemaker. Review of facility investigation documentation dated December 27, 2011 which was signed, dated and provided by the Executive Director (ED) on February 10, 2012 revealed the ED was the first person notified, the resident's physician was not notified and included " ... I heard someone banging on a door. I came upon (resident) trapped in (resident's) room due to a lock malfunction. I broke the lock off and opened (resident's) door, (Resident) stated...had been trapped for 15 hours and two people came to (resident's) door and left to get help and never returned." Review of facility investigation documentation dated December 27, 2011 and initialed by the ED revealed "...oriented to time and place incident of (resident) door being locked for full shift... (Medical Technician #3) states (resident) was locked in...room and I reported it to (Med Tech #5)...(Med Tech #5) states...door was locked...she tried to open the door but was unable to get it open...time line shows: ...Making rounds at 10:45 pm (p.m.) found...door locked...reported...all (staff) went upstairs to try and open door...(Resident) was in (resident's) room 14 or 15 hours..." Review of facility investigation documentation signed by Med Tech #5 and dated December 30, 2011 revealed "...(resident) said (resident) could not open...door this was about 12:00 midnight...l attempted to help...by rambling (ramming) the door with my shoulder and still could not get the door open...told (resident) that I would tell ..

GQ8511

| <u>Division</u> | of Health Care Faci | lities | | | | OW DATE D | IBVEY |
|---|--|---|---|---------------------------|---|---------------------------------|------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDING | | (X3) DATE SI COMPLE | TED |
| • | | TNPL53766 | • | B. WING | | 03/0 | 1/2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADI | RESS, CITY, S | TATE, ZIP CODE | | |
| | FT OF TWIN HILLS | | 94 TWIN I MADISON | HILLS DRIVE , TN 37115 | | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL [| ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY | ION SHOULU BE HE APPROPRIATE | COMPLETE DATE |
| D 713 | (Maintenance Direct saw (Maintenance clocking out to go it open (opened) the revealed, "I am nthis is a fire hazz. Review of facility in signed by Medical February 10, 2012 inroomInotify who was (were) we incident. I try (tried (ramming) the doo | ctor) when he gets in Director) it was when nomebut he had all door" Continued r ot to let this happen | i I was ready eview again ntation ated ced vloyees ring the raming | D 713 | | | |
| | February 9, 2012 a office revealed on a.m. the Maintenar changing a light but beating on a door (Resident) said (reand door wouldn't all nighttold me pass not working proome back and ne morning! broke the room and repations | Maintenance Director at 3:35 p.m. in the ma December 27, 2011 nce Director was ups allo and he stated, " lock was altered in a sident) had bent level open(resident) salo beople had come whi roperly and had said ver didI told (ED) to he lock off to gain ac ired (lock) that morn | arketing at 8:30 stairs I heard some way. Fr down there door they would hat cess to ing." | | | - 3-35 - 3-35 | |
| | February 9, 2011 a lounge revealed the wheelchair was be resident had lived a three to four month revealed the reside walker and the reside Goffa think. | Iterview with the resist 3:47 p.m. In the from the resident seated in side the resident, an at the facility for applies. Continued intervient used the wheelch ident stated, "was I was actually locker went to the door and | ent entry a chair, a d the coximately ew hair as a locked d insideI | | | | |

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 03/01/2012 B. WING **TNPL53766** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37115 ELMCROFT OF TWIN HILLS PROVIDER'S PLAN OF CORRECTION ഗ്ര COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG D 713 Continued From page 30 D 713 open...didn't use the call light. Someone told me it didn't work...locked in the biggest part of the day...during night into early morning...I just felt trapped. I knocked on the door trying to get attention..." Interview with the ED and the Vice President of Resident Services on February 10, 2012 at 10:30 a.m. in the marketing office revealed the facility had investigated and substantiated that resident was locked in the resident's room on December 27, 2011. Continued interview confirmed the facility failed to provide protective care to Resident #20 on December 27, 2011. C/O: #29126, #28393 D 714 D714 D 714 1200-08-25-,07 (7)(a)2. Services Provided (7) An ACLF shall provide personal services as Corrective action for residents follows: affected: • (a) Each ACLF shall provide each resident with Resident #2 was discharged from at least the following personal services: the facility on December 24, 2011. Medications will be safely Safety when in the ACLF; administered by licensed nurses to residents #19, 35, 41 and 42. Residents number 5,30,31,34 and 36 have been discharged from the This Rule is not met as evidenced by: Based on medical record review, review of a facility. facility Acuity discharge Planning Report, review of a police report, review of facility staffing schedules, review of a Job Description, review of a list of facility employees, and interview, the facility falled to provide personal safety for one resident (#2) of twenty residents reviewed and failed to safely administer medications to two

GQB511

| SUMMARY STATEMENT OF DEFICIENCIES ID FROM DEPORT ACTION SHOULD BE CO | <u>Division</u> | of Health Care Fac | <u>lities</u> | | , | | | r <i>i≡e</i> . ⊶6:4, [‡] - , |
|---|-------------------------|---|---|---|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER ELMCROFT OF TWIN HILLS O(A) ID PREPAY ERGULATORY OR LSC IDENTIFYING INFORMATION) D 714 Continued From page 31 residents (#5, #19) of twenty residents reviewed and eight residents identified by the califlity (#5, #30), #31, #34, #34, #44, #42) of forty-buo sampled residents on three of three shifts. The findings included: Resident #2 was admitted to the facility on June 30, 2011 with diagnoses including Dementia. Review of an "Aculty Discharge Planning" report dated December 92, 2011 revealed the resident required care necessary in a secured unit (facility not licensed for secured unit). Medical record review of a Chart Note dated December 24, 2011 at 10:00 p.m. revealed, "discovered in room by cere attendantbleeding from nose, ear, mouth, and jaw appeared to be swellinghad beat (resident) with cane" Review of a police report dated December 24, 2011 revealed medication with cane Review of the staffing schedule and interview with the Resident Services Director (RSD) on February 1, 2012 at 1:48 p.m. in the Executive Director s(ED) office revealed Medication Supervisor, #2, Care Associate (CA) #2, OA #5 and Medical Technician #3 were scheduled to work the evening shift on December 24, 2011. Interview with CA) #2 on February 1, 2012 at 3:00 p.m. in the ED's office revealed CA #2 observed Resident #2 asleep between 7:30 p.m. and 6:00 p.m. Confinued interview eveled CA #2 observed Resident interview well be not continued from the resident shart could not the residents who require assistance. STREET ANDRESS, CITY, STATE, IPP CODE PROVIDERS PLAN OF CORRECTION #400 CAS ACCHORD TO IN EACH CORNECTION #400 DECACHORD TO IN EACH CONSTRUCTION #400 DECACHORD TO IN EACH CONSTRUCTION #400 DECACHORD TO INTERVIEWED TO INTER | STATEMENT AND PLAN C | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM | R/CLIA MBER: | | | COMPLETE | D. |
| STRIEST ADDRESS, CITY, STATE, ZP CODE | | | TNPL53766 | | B, WING | | | 2012 |
| ELMCROFT OF TWIN HILLS 94 TWIN HILLS DRIVE ADDISON, TN 37115 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PALL) TAGE 10 PREFIX TAGE 10 PREFIX TAGE 11 Continued From page 31 11 residents (#\$, #19) of twenty residents reviewed and eight residents identified by the facility (#\$5, #30, #31, #34, #35, #36, #41, #42) of forty-two sampled residents on three of three shifts. 11 The findings included: 12 Resident #2 was admitted to the facility on June 30, 2011 with diagnoses including Dementia. 13 Review of an "Aculty Discharge Planning" report dated December 9, 2011 revealed the resident required care necessary in a secured until (facility not licensed for secured unit). 13 Medical record review of a Chart Note dated December 24, 2011 at 10:00 p.m. revealed, "discovered in room by care attendant. bleeding from nose, ear, mouth, and law appeared to be swellinghad beat (resident) with cane" 14 Review of a police report dated December 24, 2011 revealed, "Victim (Resident #2)aggravated assautblunt object" 15 Review of the staffing schedule and interview with the Resident Services Director (RSD) on February 1, 2012 at 148 p.m. in the Executive Director's (ED) office revealed Medication Supervisor #2, Cane Associate (CA) #2, CA #5 and Medical Technician #3 were scheduled to work the evening shift on December 24, 2011. 16 Interview with CA) #2 on February 1, 2012 at 3:00 p.m. in the ED's office revealed CA #2 observed Resident #2 asleep between 7:30 p.m. and 6:00 p.m. an | NAME OF P | ROVIDER OR SUPPLIER | | | | | | , - |
| D 714 Continued From page 31 residents (#5, #19) of twenty residents reviewed and eight residents identified by the facility (#5, #30, #31, #34, #35, #36, #41, #42) of forty-two sampled residents on three of three shifts. The findings included: Resident #2 was admitted to the facility on June 30, 2011 with diagnoses including Dementia. Review of an "Aculty Discharge Planning" report dated December 9, 2011 revealed the resident required care necessary in a secured unit (facility not licensed for secured unit). Medical record review of a Chart Note dated December 24, 2011 at 10:00 p.m. revealed, "discovered in room by care attendant. bleeding from nose, ear, mouth, and jaw appeared to be swellinghad beat (resident) with cane" Review of a police report dated December 24, 2011 revealed minimistration, March 20, 21 and 22, 2012 to ensure instruction was given that only licensed personnel may administration, March 20, 21 and 22, 2012 to ensure instruction was given that only licensed personnel may administration, March 20, 21 and 22, 2012 to ensure instruction was given that only licensed personnel may administration, for secured and administration, March 20, 21 and 22, 2012 to ensure instruction was given that only licensed personnel may administre medications to residents. Additional licensed nurses were hired covering first and second shifts, to administer medication to the residents who require assistance. Interview with CA) #2 on February 1, 2012 at 3:00 p.m. and 8:00 n.m. Continued interview revealed CA #2 observed Resident #2 asleep between 7:30 p.m. and 8:00 n.m. Continued interview revealed CA #2 observed are not at the facility, there will be not all the process of the facility of the process of the facility of the process of the same licensed nurses are not at the facility. There will be not all the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of the process of th | • . | _ | | 94 TWIN H MADISON, | IILLS DRIVE TN 37115 | | | |
| residents (#5, #19) of twenty residents reviewed and eight residents identified by the facility (#5, #30, #31, #34, #35, #36, #41, #42) of forty-two sampled residents on three of three shifts. The findings included: Resident #2 was admitted to the facility on June 30, 2011 with diagnoses including Dementia. Review of an "Aculty Discharge Planning" report dated December 9, 2011 revealed the resident required care necessary in a secured unit (facility not licensed for secured unit). Medical record review of a Chart Note dated December 24, 2011 at 10:00 p.m. revealed, "discovered in room by care attendantbleading from nose, ear, mouth, and law appeared to be swellinghad beat (resident) with cane" Review of a police report dated December 24, 2011 revealed, "victim (Resident #2)aggravated assaultblunt object" Review of the staffing schedule and interview with the Resident Services Director (RSD) on February 1, 2012 at 1:48 p.m. in the Executive Director's (ED) office revealed Medical Technician #3 were scheduled to work the evening shift on December 24, 2011. Interview with CA) #2 on February 1, 2012 at 3:00 p.m. in the ED's office revealed CA #2 observed Resident #2 asleep between 7:30 p.m. and 8:00 p.m. Ontinued interview revealed CA #2 observed Resident #2 asleep between 7:30 p.m. and 8:00 p.m. and 8:00 p.m. and 8:00 p.m. ontinued interview revealed CA #2 observed are not at the facility, there will be given medication, if assistance is needed, by licensed personnel to ensure personal safety. It is the practice and policy of Elmcroft that all medication be prepared and administered by the same licensed nurse. Measures and systematic changes to prevent recurrence: Measures and systematic changes to prevent recurrence: The Executive Director inserviced staff on medication administration, March 20, 21 and 22, 2012 to ensure instruction was given that only licensed personnel may administer medications to residents. Additional licensed nurses and systematic changes to prevent recurren | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY | FULL | PREFIX | (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR | いたのねだ | (X6) COMPLETE . |
| and eight residents identified by the facility #5, #30, #31, #34, #35, #36, #41, #42) of forty-two sampled residents on three of three shifts. The findings included: Resident #2 was admitted to the facility on June 30, 2011 with diagnoses including Dementia. Review of an "Aculty Discharge Planning" report dated December 9, 2011 revealed the resident required care necessary in a secured unit (facility not licensed for secured unit). Medical record review of a Chart Note dated December 24, 2011 at 10:00 p.m., revealed, "discovered in room by care attendantbleeding from nose, ear, mouth, and jaw appeared to be swellinghad beat (resident) with cane" Review of a police report dated December 24, 2011 revealed, "Victim (Resident #2)aggravated assaultblunt object" Review of the staffing schedule and Interview with the Resident Services Director (RSD) on February 1, 2012 at 1:48 p.m. in the Executive Director's (ED) office revealed Medicaliton Supervisor #2, Care Associate (CA) #2, CA #5 and Medical Technician #3 were scheduled to work the evening shift on December 24, 2011. Interview with CA) #2 on February 1, 2012 at 3:00 p.m. in the ED's office revealed CA #2 observed Resident #2 asleep between 7:30 p.m. and 8:00 p.m. Continued interview revealed CA #2 observed Resident #2 asleep between 7:30 p.m. and 8:00 p.m. Continued interview revealed CA #2 | D 714 | • | _ | eviewed | D 714 | - | | |
| and Medical Technician #3 were scheduled to work the evening shift on December 24, 2011. Interview with CA) #2 on February 1, 2012 at 3:00 p.m. in the ED's office revealed CA #2 observed Resident #2 asleep between 7:30 p.m. and 8:00 p.m. Continued interview revealed CA #2 on call nurses to cover. The | | and eight residents #30, #31, #34, #35 sampled residents The findings include Resident #2 was a 30, 2011 with diagrams and licensed for selection of licensed for selection of licensed for selection attendantbleeding jaw appeared to be with cane" Review of a police 2011 revealed, "" Review of a police 2011 revealed, "" Review of the staff the Resident Service February 1, 2012 and prector's (ED) office and resident Service Police 2015 and revealed and review of the staff the Resident Service Police 2015 and revealed and review of the staff the Resident Service Police 2015 and revealed and review of the staff the Resident Service Police 2015 and revealed and review of the staff the Resident Service Police 2015 and revealed | identified by the facility, #36, #41, #42) of for on three of three shifted: dmitted to the facility moses including Demility Discharge Planning, 2011 revealed the ressary in a secured uncured unit). Item of a Chart Note of at 10:00 p.m. revealed the researd unity. Item of a Chart Note of at 10:00 p.m. revealed unity. Item of a Chart Note of a swellinghad beat report dated Deceming with the saultblunt object Ing schedule and integes Director (RSD) of at 1:48 p.m. in the Exice revealed Medicati | ity (#5, orty-two its. on June entia. g" report esident nit (facility lated aled, outh, and (resident) ber 24, " erview with on ecutive ion | | Per Elmcroft policy, residents be given medication, if assist is needed, by licensed person to ensure personal safety. It practice and policy of Elmcrothat all medication be prepa and administered by the sami licensed nurse. Measures and systematic club to prevent recurrence: The Executive Director and Resident Services Director in serviced staff on medication administration, March 20, 22, 2012 to ensure instructing given that only licensed per may administer medication residents. Additional licens nurses were hired covering | nnel is the oft ared hanges n- 1 and on was sonnel s to sed first | |
| 9:45 p.m. and CA #2 stated, "was covered with | | and Medical Techi work the evening s Interview with CA) p.m. in the ED's of Resident #2 aslee p.m. Continued int | nician #3 were sched shift on December 24 #2 on February 1, 20 fice revealed CA #2 of p between 7:30 p.m. erview revealed CA # ant #2's room at appro- | uled to 1, 2011. 012 at 3:00 observed and 8:00 #2 oximately | | require assistance. During times when licensed are not at the facility, there | i nurses will be | |

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIE | R/CLIA | (X2) MULTIS | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|------------------------|---------------------------|--|--|
| | OF CORRECTION | IDENTIFICATION NUT | MBER: | A. BUILDING | 3 | С |
| | | TNPL53766 | | B. WING | | 03/01/2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TATE, ZIP CODE | |
| | FT OF TWIN HILLS | | 94 TWIN H MADISON | IILLS DRIVE , TN 37115 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY) | DED BE COMPLETE |
| D 714 | Continued From pa | nge 32 | | D 714 | licensed nurse scheduled to | e on |
| . 0714 | _ | _ | 050 | | call will be responsible for cli | |
| | coming from mouth | m jaw, gobs out of n n (and) blood from rig | ht ear" | | coverage. The on call schedu | |
| · | | | i | ·. | completed by the Resident S | |
| | Telephone interview with Medication Supervis #2 on February 2, 2012 at 1:55 p.m. revealed | | pervisor realed the | | Director monthly. The licens | |
| | resident was forget | tful and she stated " | .needed | • | personnel will be assigned as | |
| | almost total care | typically 2-3 caregive | rs and | | charge nurse during the shift | |
| | me" | • | | | are covering to be held | 1 |
| | Interview with CA# | #2 on February 9, 20 narketing office revea | 12 at | | accountable for staff supervi | sion. |
| | assignment on the | evening of December | er 24, | | The Resident Services Direct | oror |
| | 2011 included seve | en totally dependent i | residents. | | Pharmacy Consultant will | |
| | Continued Intervieve | w revealed three care after 8:00 p.m., (12-2 | egivers 4-12) after | | supervise the licensed nurse | s and |
| | CA #5 went off dut | y at 8:00 p.m. | , | | will monitor for compliance | |
| | | • | un #3 on | | observing medication passes | |
| | i elepnone interviel February 7, 2012 a | w with Police Detecti it 10:05 a.m. reveale | d Resident | | evaluating performance. Th | |
| | #2 had expired, an | autopsy had been p | erformed - | _ | be done one time per quarte | |
| | and complications | of blunt force trauma | was the | , | two quarters, and annually (| |
| | cause of death. | • | | | forward, documented on a | - الله المراجع من من المراجع المراجع المراجع المراجع المراجع المراجع المراجع المراجع المراجع المراجع المراجع المراجع |
| ` | Review of an Acuit | y Discharge Planning | g Report | | spreadsheet to be reported | to the |
| | dated December 9 | . 2011 provided by th | ie ED on | | Quality Service Manager for | |
| | repruary /, 2012, l twenty-six resident | revealed the facility of sincluding Resident | s #2 and | | review. | |
| | #5 required "imme | diate Move-out." Cor | ntinued | | j | |
| | review revealed the | e following: | | | The Executive Director and | |
| | Resident #2; nes | eds secure unit | • | | Resident Services Director h | |
| | Resident #5: Hos | spice; Total Care | | | been in-serviced on the pro | per ··· |
| • | Resident #6: Tot | al Care | total care | ٠ | · completion of an abuse | |
| | Resident #7: 104 | years old; hospice; on-ambulatory; total o | саге | ĺ | investigation including notif | |
| | Resident #9: W | ound on heel | | | the appropriate authorities | by the |
| | Resident #24: To | otal Care | | ŀ . | Quality Services Director, M | larch |
| | Resident #25: No | on-ambulatory on-amb (non ambula | tory), two | <u> </u> | 19, 2012. | : चक्क व्यक्ति |
| | person transfer - H | lospice | | <u> </u> | | |
| Division of H | ealth Care Facilities | , | | 8899 (| GQB511 | If continuation sheet 33 b |

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C: . . B. WING . 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE, NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE ELMCROFT OF TWIN HILLS MADISON, TN 37115 COWNETELE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 714 Continued From page 33 **Executive Director and Resident** Resident #27: Needs secure unit Services Director in-serviced the Resident #28: Total Care... entire staff March 20, 21 and 22, Resident #29: Total Care... 2012 on incident reporting, the Resident #30; Two person tranfer Resident #31: Confused; non-ambulatory completion of the incident report Resident #32: Total Care and chain of command, thorough Resident #33: Blind; Total Care investigation of alleged abuse, Resident #34: Wanders; needs secure unit Resident #37: Total Care including those incidents which Resident #38: Confused; total care require notification to the TN Resident #39: Non-ambulatory -Department of Health, Adult Protective Services and other Review of a letter from the facility and dated authorities including the police if January 18, 2012 revealed, "...Notice of Discharge and Transfer...(Resident #39)...has necessary. needs that cannot be safely and effectively met in the Community (assisted living facility)..." Residents # 2, 5, 6, 7, 8, 9, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, Review of letters from the facility and dated 37, 38 and 39 have been January 19, 2012 revealed, "...Notice of Discharge and Transfer...(Residents #8, #24, discharged from the facility. #25, #26, #27, #28, #29, #30)...has needs that cannot be safely and effectively met in the Per the Elmcroft policy, residents Community..." will be provided sufficient staff to Review of letters from the facility and dated meet their needs. As stated in the January 20, 2012 revealed "... Notice of Discharge regulations, 1200-08-25-.12 under and Transfer...(Residents #34, #40)...Notice of Resident Records, page 32 number Discharge and Transfer...has needs that cannot be safely and effectively met in the Community..." 4; An ACLF shall complete a written assessment of the resident Review of the facility's current census dated to be conducted by a direct care January 30, 2011 revealed eighteen of the residents identified by the facility in the report staff member within a time-period dated December 9, 2011 remained in the facility. determined by the ACLF, but no later than seventy two (72) hours Interview with the Chlef Operating Officer on January 31, 2012 at 9:00 a.m. in the ED's office revealed the facility had twenty-two current

| Division | of Health Care Faci | | | | | (X3) DATE SUR | VEY |
|--------------------------|--|---|-----------------------|---------------------|--|----------------|--------------------------|
| | OF DEFICIENCIES | AND PROVIDERISUPPLIE | R/CLIA | (X2) MULTIPL | E CONSTRUCTION | COMPLETE | ^{ED} (|
| AND PLAN C | ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | A BUILDING | <u> </u> | CC | 1 |
| | • | TNPL53766 | | B. WING | | 03/01/ | 2012 |
| | | INPLOSTED | STREET ADDI | RESS, CITY, ST | ATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | · | 94 TWIN H | LLS DRIVE | • | • | |
| ELMCRO | ft of twin Hills | | MADISON, | TN 37116 | | TION | |
| (X4) ID PREFIX TAG | | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM | 1000 | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | 1ULU DE 1 | (X5) COMPLETE DATE |
| | | | | D 714 | after admission; however is | n all` | |
| D714 | | | | | reasonable opportunities a | j | |
| | residents for whom | n the facility was una | d the | } | licensed nurse conducts th | e | ; |
| | provide the require | ed care and confirme clent staff to meet the | needs of | . | assessment per our policy. | it is | • |
| | the residents. | • | | ļ | not acceptable practice for | a | |
| | | | | | Community Relations Dire | ctor to | İ |
| 1 | | | | . [| conduct an assessment. A | licensed | |
| | Review of a list of | employees dated Fe | bruary 2, | | nurse does an assessment | per our | |
| | l and and arouids: | d by the Executive Di revealed six employe | ilector our li | | policy prior to move in, aff | er 30 | |
| | February 2, 2012 designated as Me | edication Technicians | | | days, every 6 months or u | pon a | |
| | | · | | | change of condition or ret | urn from 🗋 | \$ 1.45A |
| | Review of a Job I | Description dated Jar Position Title: Certifie | iuary i, d Nursing | | an alternative setting such | t as, | |
| 1 | LAccident (CNA)// | Resident Assistanvivi | edicanou: | | hospital, rehab/skilled car | e or | 10 20 |
| } | I Tasknisian/Darca | mai Care Aide Pusi | | } | home dependent upon th | е | A. 102.1.7 |
| 1 | Summary Provide | es personal care for I f nursing staffNo m | redication | | residents needs as detern | nined by ., | |
| | L AFFACE AD JORN MA | dication administered | 1 OI | | the level of care assessme | ent, · · · · · | |
| | Laurandeed Sur | ANISON KESDONSIDII | HICO IIIIO | | | | |
| | Terrordal Dutice | supervisory respons | 12fen beiest | 1 | | | Here and the second |
| * | I are ecoroconfolist | a of the knowledge, (| PIVINI, GIVA OF | | · | | |
| | I - Little required | Verities identity of its | 3810CHL | 1 | | | |
| | i /madiaation odim | ition, checks the MAF Inlstration record) to | DOCUIO | | | | |
| 1 | | sa le noind diven, alik | 1 Lecordo | | 1 | • . | |
| | il et E a desiniata | otion saministers i | HEGICATION IN | ' | | • | |
| | Absolute Deci | ation is being taken a ident to detect respon | 19C 10 | | | | |
| - | i annuitied house o | t medications | Militrarionia | | | | |
| | Education: High School or GED preferredMedication Technician certification where | | 1100 | ľ | • | | |
| 1 | Medication Tec required." | Chalcian Certification | | | | | -3.2% |
| | į · | | 0 | | | | |
| | Telephone Interv | view with Medication | evealed " | 1 | | | 11. 201 |
| | #2 on February | 2, 2012 at 1:55 p.m. i medications) and ma | nage staff | | | | 1.18 |
| | pass out meds (medications) and manage staff on my shift" | | | | | | 1700 |
| | | · | | <u> </u> | | | |
| | Leath Coro Facilities | | | | | If continue | ation sheet. 35. |

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION 03/01/2012 B, WING, TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37115 ELMCROFT OF TWIN HILLS PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG D 714 On March 8, 2012, all existing Continued From page 35 D 714 residents were assessed by Telephone interview with Medication Supervisor #1 on February 7, 2012 at approximately 9:45 licensed nurse per the policy to a.m. revealed " ... pass Lortabs, Amblen, pretty ensure their appropriateness for much regular narcotics..." Assisted Living. Interview with Medication Technician (MT) #1 on February 7, 2012 at 1:45 p.m. in the first floor Corrective Action: medication room revealed MT #1 worked first shift and MT #1 stated "I do fingersticks, give eye Medication pass tracking and the drops, ear drops, inhalers..." facility abuse policy and protocol for reporting and the level of care Interview with MT #4 on February 7, 2012 at 3:38 p.m. in the first floor corridor revealed "...no assessment which is completed difference in a med tech and med tech supervisor prior to move in, after 30 days, ...I do eye drops for (Resident #41, #42, #30, every 6 months or upon a change #19)..." of condition or return from an Interview with MT #2 on February 7, 2012 at 2:10 alternative setting such as, p.m. in the first floor medication room revealed hospital, rehab/skilled care or the medications he administered to Resident #18 on February 7, 2012 included Hydrocodone and home, and labor hours will be Metformin (medication that effects blood sugar reviewed by the Quality Assurance levels). Continued interview revealed he did not know what Metformin was, and he stated, " ... i Committee consisting of the don't know what side effects to watch for." Executive Director, Resident Continued interview revealed he monitored for Services Director, Resident dizziness/faintness after administration of Warfarin (medication that effects the ability of Services Coordinator, blood to clot) and he stated " ... If I notice (adverse Maintenance Director, Dining side effects) i report to my supervisor (MT #1)." Services Director, Business Office Further interview revealed "I give eye drops to Coordinator and Healthy Lifestyles (Resident #19)..." Director, monthly. 4-10-Interview with MT #1 on February 10, 2012, at 9:20 a.m. In the first floor corridor revealed she had administered insulin injections to sampled Resident #35 and she stated "...most recently a . couple of months ago...but I have given injections. Know I'm not supposed to."



| Division | of Health Care Faci | ilities | | | | (X3) DATE SL | JRVEY |
|--------------------------|--|--|--|------------------------------|---|-----------------|--|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIE | R/CLIA | 1, , | LE CONSTRUCTION | COMPLE | TED |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NO | MDCX | A, BUILDING B, WING | | - C | ; 1/20 <u>12 </u> |
| | | TNPL53766 | <u> </u> | | | 0070 | <u> </u> |
| NAME OF P | ROVIDER OR SUPPLIER | | | RESS, CITY, S HILLS DRIVE | TATE, ZIP CODE | | |
| ELMCRO | FT OF TWIN HILLS | | MADISON | TN 37115 | • | | T |
| (X4) ID PREFIX TAG | ARYON DEELCIENC, | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM | TULL ! | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE | THE APPROPRIATE | COMPLETE DATE |
| D 714 | residents' mouths, interview revealed specific medical te administer insulin mean in their stor shots." Interview with MT 11:25 a.m. in the frevealed he had a residents discharg #36, #31). MT #2 (pills) into resident #34), nobody else to(former ED) w certification to pas nurse was supposed to the Executive Dires 13 a.m. in the medicality falled to ad qualified staff. The (certified). They're understanding. Do a Med Tech on the to be doing patient the meditech can pass. That's the woods a medical to the execution and in the meditech can pass. That's the woods a medited the meditech and in the meditech and in the meditech can pass. That's the woods a medited the meditech and in the meditech and | age 36 Associate (CA) #4 (at 10:00 a.m. in the she had witnessed Minister medications intinject insulin. Contin CA #4 was unable to echnician she had witinjections. She stated achs A lot of them #2 on February 10, 2 first floor medication is dministered insulin to jed from the facility (I stated " i have pour ts' mouths (Residents, not aware (I am) no she told me (I) did not is meds new composed to be passing medication of the facility finade to the Executive 12 at 9:13 a.m. Interestor on February 8, anarketing office confirminister medications in ED stated "They are to be certified to my on the care of the confirminister medications are cart (medication) in the care. If a nurse is of the care after way I staff in this build interview with MT #2 between 8:40 a.m. a following: MT #2 himpled Resident #5 in the part of the passident #5 in the part of the passident #5 in the passident # | trist noor edical or used or identify a nessed of "You give insuling two Residents and said a nessed any said a nessed any said a nessed any said a nessed any said a nessed any said a nessed any said a nessed any said a nessed any said a nessed any said a nessed any said a nessed any said a nessed any said a nessed any said a nessed any said a nessed any said a nessed any said and sa | | | | |
| Division of H | lealth Care Facilities | | | 6599 | GQB511 | if continue | o. 15 Janea nobe |

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIES | R/CLIA | | E CONSTRUCTION | (X3) DATE SU COMPLE | IED |
|--------------------------|--------------------------------|---|----------------|------------------------|---|------------------------|---|
| ND PLAN OF | CORRECTION | IDENTIFICATION NUM | | A BUILDING B. WING | | | /2012 |
| | | TNPL53766 | | | | | |
| LAME OF PR | OVIDER OR SUPPLIER | 1 | STREET ADD | RESS, CITY, ST | ATE, ZIP GODE | | |
| | | • | 94 TWIN H | ILLS DRIVE TN 37115 | | · · | · · · · · · · · |
| ELMCROF | T OF TWIN HILLS | | <u></u> | | PROVIDER'S PLAN OF COR | RECTION | (X6) COMPLETE |
| (X4) 1D PREFIX TAG | 45 ALL BETTOICNE | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM | , | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SUCCES OF | DATE |
| | | | | D 714 | | | |
| D 714 | Continued From p | age 37 | | · · · | | | |
| 1 | medication cup. M | ledical record review | of the | . | | • | |
| | Medication Admin | istration Recolu teve | owing | | | | |
| . 1 | dia - Negari Effor | vor XIR I Denakoje ov | 11(1Vies 150) | | | | 1 |
| 1 | -100 eromo (-100) $+$ | 191001 U.S. 111U., 211U N | Chhin oco | | | | |
| | ぶっ /The entire | of Depakote and Ef | ICVOI | | | | |
| ļ. | AIT AD WALLAC ON | nrayimately lilly leet | TOMS OF CITE |] | • | | 1 |
| j | 1 | וווו ב וומעע" חפופוס את | juio. | 1 | · | | 1 |
| } | Camillanad intende | SW TAMPAIRO WIL #4 U | G HOLKHOW | | | • | |
| 1 | aua A4 O4EA 6 M | Depakote Sprinkles, , the facility's Quality | A COLLAIOCA | | | • | رو مب |
| | ****************************** | amived at the fileulua | HOLL COLL | | | | |
| | and MT #2 walke | a away. At approxim | ately 0.00 | [· | | • • | |
| , | OCM a Licensed | rned and stated "I go Practical Nurse) cat | 120 1101 | | | | |
| | | h made and (Kesiut) | (IL 160) | | | • | 1 |
| ļ | l use sees a lot and | MOSMA WID DAVE LU L | TIAC FIGURE | | | • | , |
| • | l regident to an Un | 8:59 a.m., MT #2 as | nia ai~ | | · | | |
| | OCM administra | sa the menication. O | Nithing A | | } | ., | |
| | abconstion rave | aled the QSM did No | (Kilhai me |] | | | 242 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |
| | administration of | the resident's medic | attori. | | | | 1 |
| | Interview with the | e facility's Quality Ass | surance | | • | | |
| | 1 | AN GANRIONIA ZULA | at 0,40 4 | | | | . Magazin |
| | to the medications | office revealed it was | 2 1106 0000 00 | 1 | | | |
| | 1 | sa OSM administeret | 4 | | | | |
| | i medications she | had not brepared to | sampled | | | • | ľ |
| | Resident#5 on I | February 8, 2012. | | | | | |
| | C/O #:28393, #2 | 9126 | | | | • | |
| D 716 | 1 | (7)(a)4. Services Pro | | D 716 | | | 200 |
| • | follows: | all provide personal | | | | · | |
| | (a) Each ACLE | shall provide each re | esident with | | | | ustion sheet. |

| <u>Division</u> | <u>rof Health Care Fac</u> | llities | | | | | |
|--------------------------|--|---|----------------------|-------------------------|--|------------|--------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE | R/CLIA MBER: | (X2) MULTI | PLE CONSTRUCTION | COMPLE | URVEY TED |
| | | TNPL53766 | | B. WING 03/01/20 | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADD | RESS; CITY, S | STATE, ZIP CODE | | |
| ELMCRO | PET OF TWIN HILLS | | | IILLS DRIVI TN 37115 | | | · |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | DULD BE | DATE COMPLETE (X9) |
| D 718 | Continued From pa | age 38 | | D 716 | | | |
| • | | g personal services: | 1 | | <u>D716</u> | : | |
| | The ability and crises arise; | readiness to interver | ne lf | | Corrective action for resider affected: | <u>nts</u> | |
| | | • | | : | The facility will appropriately intervene with ability and | | مرابع فيدرو |
| | This Rule is not met as evidenced by: Based on medical record review, review of a police report, review of facility staffing schedules, review of facility investigation documentation, observation, and interview, the facility falled to appropriately respond for one resident (#2) | | | | readiness in the event of a c Resident #2 is no longer at t facility. He was discharged of 24-2011 to the hospital. | his 💮 | |
| | intervene for one re room; facility failed meet the needs for | I assault; failed to tiresident (#20) locked to provide sufficient two residents (#2, #2, #2) residents reviewed. | Inside a staff to | | Resident #14 is no longer at facility. He was discharged of 24-2011 to a Behavioral Hea | on 12- | |
| | The findings includ | ed: | | | Resident #5 is no longer at t | | |
| | | imitted to the facility loses including Demo | | | facility. She was discharged 14-2012 to a Nursing Home. | · | |
| | dated December 9, | by Discharge Planning 2011 revealed the ressary in a secured un sured unit). | esident | | Resident #20 will have prote provided as stated in the individualize service plan as | well | California (|
| | December 24, 2011 "discovered in rocattendantbieeding | ew of a Chart Note d f at 10:00 p.m. revea om by care g from nose, ear, mo swellinghad beat (| iled, uth, and | | as following the standards, we state that a member of management will see every resident daily. | vhich | |
| | Review of a police r 2011 revealed, "V | report dated Decemb ictim (Resident | er 24, | | | ap | 100 |

If continuation sheet 39 of 6

| Di <u>vision</u> | of Health Care Faci | iltles | | Τ | | (X3) DATE SUR | VEY |
|------------------|----------------------------------|---|-----------------------|------------------------|--|---------------|------------------|
| STATEMENT | OF DEFICIENCIES | MAN PROVIDERISUPPLIE | R/CLIA | | E CONSTRUCTION | COMPLETE | Đ , |
| AND PLAN C | F CORRECTION | IDENTIFICATION NUM | ирек: | A. BUILDING B. WING | | 03/01/ | 2012 |
| | | TNPL53766 | | _ | | 03/01/ | 3 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ATE, ZIP CODE | • | |
| | FT OF TWIN HILLS | | 94 TWIN H MADISON, | ILLS DRIVE TN 37115 | | | |
| ELINICKO | | | | | PROVIDER'S PLAN OF CORREC | TION | (X6) COMPLETE |
| (X4) ID | アファット ロロビグにいび | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY | rou. | ID PREFIX | (EACH CORRECTIVE ACTION SHO | 10000 | DATE |
| PREFIX TAG | REGULATORY OR I | LSC IDENTIFYING INFORM | ATION) | TAG | DEFICIENCY) | | |
| | | | | D 716 | ······································ | 1 | |
| D 716 | Continued From pa | | _ | | Other Residents that could | | |
| | #2)aggravated a | ssaultblunt object | ." | | potentially be affected: | | |
| | Review of the staf | fing schedule and into | erview with | | Staff will be provided an | | |
| | the Decident Sent | ices Director (Kov) v | 111 | | individualized service plan b | v the | , : |
| | February 1, 2012 | at 1:48 p.m. in the Exice revealed Medicat | lon | | supervisor each shift that w | in l | |
| | Supervisor#2 Ca | re Associate (CA) #4 | , CM#0 | | ensure that all the residents | , | • |
| • | l and Modical Tech | nician #3 were sched shift on December 24 | iuleu io | | needs are met. The initial s | ervice | |
| | 1 | | | | plan is completed on the da | y of | Water ! |
| • | Interview with CA | #2 on February 1, 2 | 012 at 3:00 | .] | move in. Changes to the se | ervice 💮 | |
| | p.m. in the ED's o | ffice revealed CA #2 p between 7:30 p.m. | and 8:00 | | plan are made monthly and | l if | |
| | In m. Continued in | terview revealed CA | #2 | | there are changes in condit | ion. | |
| <u> </u> | I returned to Residu | ent #2's room at appr #2 stated, "was co | OXIMBION | | This is completed by the Re | sident | • |
| | blood blooding fi | rom law, gobs out of l | nose, | | Service Director who provide | ies it to | |
| | coming from mou | th (and) blood from r | ight ear" | - | the direct care staff. | • • | 20.00 |
| | Telephone intervi | ew with Medication S | upervisor | | The Resident Services Direc | rtor will | A ARE |
| | LAO en Cabarant 2 | - 2012 At 1155 D.M. FE | svealed use | | determine with 30 day | , | |
| ļ | I recident was fore | etful and she stated " typically 2-3 caregiv | teeaea | | assessments the level of | |] |
| j | me" | "typically 2-0 out og. | | | assistance that each reside | ent | |
| 1 | i e | Jio Falmioni O Ol | nio at | 1 | requires. The service plan | ls : | 433.7 |
| i · | I 44.05 am in the | #2 on February 9, 20 marketing office reve | Salen Hei | | checked by the licensed nu | irse or | |
| 1 | I applianment on th | e evening of Decemi | per 24, | | supervisor of the shift to e | nsure | |
| ļ | 1 2011 included se | ven totally dependen ew revealed three ca | f legineurs. | | assignments are properly | | |
| | I staffed the facility | / after 8:00 p.m., (12- | 24-12) afte | | carried out. This informat | ion is | 1 |
| | CA #5 went off d | uty at 8:00 p.m. | | | reported to the Resident S | | |
| 1 | Tolonhone inten | lew with Police Detec | tive #2 on . | | Director. | : * | |
| 1 | J E. L. J. 2012 | i at shins a m. reveal | GO Vesidon | t | 1 | . المصادر | |
| | 1 40 had ovnired s | an autopsy had been s of blunt force traun | periornes | | Per the Elmcroft policy, re | sidents | 1 |
| | and complication cause of death. | R Of Digit lotoe page | · | | will be provided sufficient | Stati to | |
| | | | | 1 | meet their needs. As stat | eu at tale | |

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С B. WING 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE ELMCROFT OF TWIN HILLS MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE PRÈFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) regulations, 1200-08-25-.12 under D 716 D 716 Continued From page 40 Resident Records, page 32 number -Resident #20 was admitted to the facility on February 1, 2011 with diagnoses including 4; An ACLF shall complete a Chronic Obstructive Pulmonary Disease and written assessment of the resident Pacemaker. to be conducted by a direct care staff member within a time-period Review of facility investigation documentation dated December 27, 2011 which was signed, determined by the ACLF, but no dated and provided by the Executive Director later than seventy two (72) hours (ED) on February 10, 2012 revealed the ED was the first person notified, the resident's physician after admission; however in all was not notified and included, "...I heard reasonable opportunities a someone banging on a door. I came upon licensed nurse conducts the (resident) trapped in (resident's) room due to a lock malfunction. I broke the lock off and opened assessment per our policy. It is (resident's) door. (Resident) stated...had been not acceptable practice for a trapped for 15 hours and two people came to Community Relations Director to (resident's) door and left to get help and never conduct an assessment. A licensed returned." nurse does an assessment per our Review of facility investigation documentation policy prior to move in, after 30 dated December 27, 2011 and initialed by the ED revealed, "...oriented to time and place incident of days, every 6 months or upon a (resident) door being locked for full shift... change of condition or return from (Medical Technician #3) states (resident) was an alternative setting such as, locked in...room and I reported it to (Med Tech #5)...(Med Tech #5) states...door was hospital, rehab/skilled care or locked...she tried to open the door but was home dependent upon the unable to get it open...time line shows: ...Making residents needs as determined by rounds at 10:45 pm (p.m.) found...door locked...reported...all (staff) went upstairs to try the level of care assessment. and open door...(Resident) was in (resident's) room 14 or 15 hours..." Review of facility investigation documentation signed by Med Tech #5 and dated December 30, 2011 revealed, "... (resident) said (resident) could not open...door this was about 12:00 midnight...l attempted to help...by rambling (ramming) the door with my shoulder and still could not get the door open...told (resident) that I would tell

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B, WING 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37115 ELMCROFT OF TWIN HILLS (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG D 716 Continued From page 41 D 716 (Maintenance Director) when he gets In...When I On March 8, 2012, all existing saw (Maintenance Director) it was when I was residents were assessed by clocking out to go home...but he had already open (opened) the door..." Continued review licensed nurse per the policy to revealed, "...i am not to let this happen again ensure their appropriateness for ...this is a fire hazzard (hazard)." Assisted Living. Review of facility investigation documentation signed by Medical Technician #3 and dated Measures and systematic changes February 10, 2012 revealed, "...was locked to prevent recurrence: In...room...l ...notify (notified) other employees who was (were) working at that time during the The Regional Director of incident. I try (tried) unlocking the door, raming (ramming) the door, and even try (tried) to pick Operations will monitor the the lock...' Executive Director weekly via an operations overview call to ensure Interview with the Maintenance Director on sufficient staff is in place to meet February 9, 2012 at 3:35 p.m. In the marketing office revealed on December 27, 2011 at 8:30 the needs of the residents. a.m., the Maintenance Director was upstairs changing a light bulb and he stated, "...! heard The facility has weekly at risk calls beating on a door...lock was altered in some way. which are designed to discuss the (Resident) said (resident) had bent lever down and door wouldn't open...(resident) sald...in there resident Quality Services as all night...told me people had come while door documented on a log, driven by was not working properly and had said they would the Quality Service Manager to come back and never did...I told (ED) that morning...I broke the lock off to gain access to monitor the Resident Services the room and repaired (lock) that morning." Director and Executive Director. This meeting is to ensure the Observation and interview with the resident on February 9, 2011 at 3:47 p.m. in the front entry facility can meet the acuity levels lounge revealed the resident seated in a chair, a wheelchair was beside the resident, and the resident had lived at the facility for approximately three to four months. Continued interview revealed the resident used the wheelchair as a walker and the resident stated "...was locked inside. Gotta think, I was actually locked inside...! couldn't get out. I went to the door and it wouldn't

(X3) DATE SURVEY COMPLETED Division of Health Care Facilities (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 03/01/2012 B. WING TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37115 ELMCROFT OF TWIN HILLS PROVIDER'S PLAN OF CORRECTION COMPLETE (EACH CORRECTIVE ACTION SHOULD BE ID SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX DEFICIENCY) TAG of the residents. A Resident D 716 Continued From page 42 D 716 Service Coordinator position was open...didn't use the call light. Someone told me it added on February 16, 2012 to be didn't work...locked in the biggest part of the responsible for scheduling with a day...during night into early morning...i just felt trapped. I knocked on the door trying to get primary focus of staffing. The attention..." staffing is determined by the Interview with the ED and the Vice President of number of residents being Resident Services on February 10, 2012 at 10:30 serviced and their individual care a.m. in the marketing office revealed the facility plan needs. The Resident Service's had investigated and substantiated that resident was locked in the resident's room on December Coordinator reports directly to the 27, 2011. The ED stated "I can prove time frame Resident Service Director. The from at least 6:30 p.m. until 6:30 a.m...The Resident Service Director will tumbler had fallen in (lock)." Continued interview confirmed facility staff neglected to timely review a sample of the care plan's intervene to provide access to/from Resident one time per week for the next 6 #20's room on December 27, 2011. weeks and ongoing as needed. The Executive Director and Resident #5 was admitted to the facility on September 11, 2009 with diagnoses including Resident Services Director have a Pick's Disease. system of checking the staffing model to ensure it is sufficient to Medical record review of a General Note dated August 1, 2011 revealed "...total assist with ADL's meet the acuity needs of the (activities of daily living)...slouched over in residents. Labor hours are wheelchair...repositioned several times, unable to reviewed Monday through Friday sit up...non-ambulatory, non weight-bearing..." Medical record review of a Chart Note dated with Executive Director, Resident September 7, 2011 revealed "...was found on the Service Coordinator and Resident floor...hit the left side of...head no redness or Service Director to ensure brulsing..." adequate staffing is utilized. This Review of an "Acuity Discharge Planning" report system is monitored weekly by dated December 9, 2011 revealed "...total care..." reporting during the regional Medical record review of Chart Notes dated operations call with the Regional December 11, 2011 revealed, "Took to room after lunch and resident slid out of chair and was on the floor...gash on left side of back of head...to

| Division | of Health Care Fac | ilities | | | | | ************************************** |
|--|--|--|--------------------------|---|---|--|--|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE (DENTIFICATION NU. | R/CLIA MBER: | A BUILDING | LE CONSTRUCTION | (X3) DATE SUI COMPLET C 03/01 | |
| NAME OF P | ROVIDER OR SUPPLIER | 1 1141 COSTOO | STREET ADI | ORESS, CITY, ST | TATE, ZIP CODE | | |
| | FT OF TWIN HILLS | | 94 TWIN I MADISON | HILLS DRIVE , TN 37115 | . • | · . | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | E APPROPRIATE DAT | |
| D 716 Continued From pa | | age 43 | | D 716 | Director of Operations and C | Quality | : |
| (hospital)returned, spoke with Dr. (doctor) stated he put staples inhead otherwiseld | | ctor) elooked | | Service Manager | · · | | |
| | fine" | os maniona omo, mo | | | Corrective Action: | | • , |
| | Medical record review of an Emergency Provider Record dated December 11, 2011 revealed | | | The facility abuse policy and protocol for reporting and ti | 1 | | |
| | "Time (2:52 p.m.) |)Historian: parame | dics NH | | level of care assessment wh | | 100000 |
| (nursing home) no cm (centimeter) lad review revealed " | | c (laceration)" Conf | inued | | completed prior to move in, | | |
| | | .non-ambulatory at nmunicative at baseli | • | | 30 days, every 6 months or | | a. grafine sagger |
| | | d of staffdespite se | | | change of condition or retu | | |
| • | attempts. When sp | ooke with Rn (Registe | ered | ` | an alternative setting such a | is, | 2,000 |
| : | Nurse) at NH they further historical inf | were unable to proiv formationstapled | ue any | · . | hospitai, rehab/skilled care | | 100 |
| | | | | | home, and labor hours will l | | |
| | 11. 2011 and Inter | g schedule dated De view with the RSD or | r February | | reviewed by the Quality Ass | | |
| | 1, 2012 at 1:48 p.m | n. In the ED's office t | evealed | [| Committee consisting of the | |] |
| | two Medical Techn scheduled to work | iician's and a CA wei the day shift. The R\$ | e SD stated | | Executive Director, Resident | τ | · |
| | "There had to be a | nother caregiver but | l don't see | [| Services Director, Resident Services Coordinator, | | |
| | lt." | | | | Maintenance Director, Dinis | ng | eveling |
| 1 | Review of Time Re | ecord Reports dated | December | | Services Director, Business | | 1 |
| | 11, 2011 provided | by the ED on Februa or the two medical ted | ity 8, 2012 Shricians | ,] | Coordinator and Healthy Lif | | |
| | and no documenta | tion regarding the so | heduled | | Director, monthly. | | 4-10-12 |
| | CA or an RN. | | | ١ ٠. | | | · ! : |
| | Observation on Fe | bruary 8, 2012 at 8:5 | 8 a.m. | | | • | med street |
| | revealed Resident | #5 was assisted by T sition and the facility | echnician Ouelik | | | • | |
| : | Services Manager | (a Licensed Practica | l Nurse) | | | - : | - |
| | administered medic | cation to the residen | t with a | | • | . 45 | |
| | spoon. Continued of Technician #2 physical placed the resident | observation revealed sically lifted the resid tonto the bed. | ent and | | | | 11.00 |
| | • | y Discharge Planning | g Report | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | ER/CLIA IMBER: | (X2) MULTIP A. BUILDING B. WING | LE CONSTRUCTION | | C 1/2012 |
|--------------------------|---|--|-----------------------------|---------------------------------------|---|-------------------------------------|-----------------|
| | | TNPL53766 | CTOCKT ADI | DEES CITY S | TATE, ZIP CODE | | |
| | ROVIDER OR SUPPLIER OFT OF TWIN HILLS | • | 94 TWIN I | IILLS DRIVE TN 37115 | • | | • |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | S · FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | COMPLET DATE |
| D 716 | dated December 9, February 7, 2012 re Residents #2 and # Move-out." | age 44 , 2011 provided by the evealed the facility de the fac | etermined ate eer on | D 716 | | | |
| D`801 | revealed the was u | nable to provide the I the facility had insu eds of the residents | required Ifficient s. | D 801 | <u>D801</u> | | |
| | continued stay of a of the following con (a) Requires treatr | not admit or permit t ny ACLF resident wi iditions: nent for stage III or s with exfoliative derr | ho has any stage IV | | Corrective action for residents affected: Residents #9 and 15 were discharged from the facility | ,- ,-, ,-, ,-, | |
| | facsimile document facility admitted and of two residents (#9 ulcers of twenty res | record review, review tation, and interview d permitted the conti 9, #15) with Stage IV sidents reviewed. | v, the inued stay | | Other Residents that could potentially be affected: Skin condition reports wer completed by Resident Sel Director on all residents rethe facility. The caregivers | e rvice siding in s report | |
| | 22, 2010 with diagr Disease and Diabe Medical record revi | dmitted to the facility noses including Park | tion of | | any unusual condition of to to the Resident Service Did The facility will not move I resident with documentat having stage III or IV press ulcers. If a resident is four | rector. in a . ion of ure | |
| | and dated August 8 | i, 2011 revealed, " patient was in whole ng medical condition | The , or in | | have a skin condition, an o | outside If continual | |

STATE FORM

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING 03/01/2012 B. WING. TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37115 **ELMCROFT OF TWIN HILLS** (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG agency will be contacted to D 801 Continued From page 45 D 801 determine if it is a stage ill or IV wound L (left) heel with MRSA (methycillin pressure ulcer. If residents are resistant staph aureus- a multi-antiblotic resistant found to have a stage III or IV organism)...very debilitated - lives in Asst (assisted) Living." Medical record review of a pressure ulcer, they will be Chart Note dated September 11, 2011 revealed, transferred to another facility or "Home Health Skilled Nursing visit for wound care of Stage IV...pressure ulcer..." Medical record we will find alternative housing to review of a Chart Note dated October 10, 2011 better meet their needs. The revealed, "...Stage 4 pressure ulcer to left heel..." Resident Service Director or a Medical record review of a Chart Note dated licensed nurse completes a level of October 20, 2011 revealed, "...returned from Hospital ...this morning..." Medical record review care assessment per our policy of a Transfer and Discharge Record dated prior to move in, after 30 days, November 11, 2011 revealed "...Reason for Transfer:..non-compliant with meds (medications) every 6 months or upon a change and had wounds on...heels..." of condition or return from an alternative setting such as, Review of a facility facsimile dated February 13, 2012 at 1:49 p.m. confirmed "(Resident #9) was hospital, rehab/skilled care or admitted with a stage IV wound." home to ensure that resident's care needs are met and that the Resident #15 was admitted to the facility on June resident is able to be appropriate 1, 2011 with diagnoses including Stage IV for Assisted Living. Pressure Ulcer. On March 8, 2012, all existing Medical record review of a Physician Statement residents were assessed by dated June 1, 2011 revealed, "...can needs be satisfactorily met in a licensed facility providing 24 licensed nurse per the policy to hour asssisted living - yes..." Medical record ensure their appropriateness for review of Resident Assessment dated June 6, 2011 and signed by the Resident Services Assisted Living. Director revealed, "...Pressure Sore St IV (Stage 4)..." Medical record review of a Chart Note dated January 9, 2012 revealed the resident was transferred to a hospital following difficulty obtaining a blood pressure reading. Medical record review revealed the resident had not

Division of Health Care Facilities ...

(X3) DATE SURVEY Division of Health Care Facilities (X2) MULTIPLE CONSTRUCTION COMPLETED : (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES c. IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION 03/01/2012 B, WING TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37115 ELMCROFT OF TWIN HILLS PROVIDER'S PLAN OF CORRECTION COMPLETE (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY** TAG Measures and systematic changes D 801 Continued From page 46 D 801 to prevent recurrence: returned to the facility. A licensed nurse will conduct skin Review of an Acuity Discharge Planning form condition reports upon move-in dated December 9, 2011 and provided by the Executive Director (ED) revealed "...Priority A and throughout the stay. (A=Immediate Move Out)...wound on coxic (coccyx)...staged a - stage 4..." Skin condition reports were completed by Resident Service interview with the ED on February 7, 2012 at 2:15 p.m. in the marketing office confirmed sampled Director on all residents residing in Resident #15 was admitted with a Stage IV the facility. The caregivers report pressure ulcer and the facility permitted the resident to stay in the assisted living facility with a any unusual condition of the skin Stage IV pressure ulcer until January 9, 2012. to the Resident Service Director. The facility will not move in a C/O: #28393 resident with documentation of D 806 1200-08-25-.08 (1)(f) Admissions, Discharges, having stage III or IV pressure ulcers. If a resident is found to and Transfers have a skin condition, an outside (1) An ACLF shall not admit or permit the continued stay of any ACLF resident who has any agency will be contacted to of the following conditions: determine if it is a stage III or IV pressure ulcer. If residents are (f) Has needs that cannot be safely and found to have a stage III or IV effectively met in the ACLF. pressure ulcer, they will be transferred to another facility or This Rule is not met as evidenced by: Based on medical record review, review of a we will find alternative housing to facility Acuity Discharge Planning report, review better meet their needs. The of a police report, observation, and interview, the Resident Service Director or a facility failed to discharge and transfer residents licensed nurse completes a level of whose needs could not safely be met for twenty-one residents (#2, #5, #6, #7, #8, #9, #24, care assessment per our policy #25, #28, #27, #28, #29, #30, #31, #32, #33, #34, prior to move in, after 30 days, #37, #38,#39, #40) of forty-two sampled residents. The findings included: if continuation sheet 4

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: ···· C-· AND PLAN OF CORRECTION A. BUILDING 03/01/2012 B. WING TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37115 ELMCROFT OF TWIN HILLS PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY) TAG every 6 months or upon a change Continued From page 47 D806 D801 of condition or return from an Resident #2 was admitted to the facility on June alternative setting such as, 30, 2011 with diagnoses including Dementia. hospital, rehab/skilled care or Review of an Acuity Discharge Planning report home to ensure that resident's dated December 9, 2011 revealed the resident care needs are met and that the required care in a secure unit. resident is able to be appropriate Medical record review of a Chart Note dated for Assisted Living. December 24, 2011 revealed, "...discovered in room...bleeding from nose, ear, mouth, and jaw Resident Service Director will appeared to be swelling...had beat (resident) with monitor residents each month by cane..." completing one random skin Review of a Police Report dated December 24, condition check to ensure the skin 2011 revealed, "...Victim (Resident condition reports are being #2)...aggravated assault...blunt object..." completed accurately and will Telephone Interview with Police Detective #1 on report findings to the Executive February 7, 2012 at 10:05 a.m. revealed Resident Director. This will be done for 3 #2 had expired, an autopsy was performed, and months and will continue one time complications of blunt force trauma was the per month, every 3 months as per cause of death. our policy. Resident #5 was admitted to the facility on Care givers were in-serviced on September 11, 2009 with diagnoses including skin care, March 29, 2012 by the Pick's Disease. Resident Service Director. This in-Review of an Acuity Discharge Planning report service included how to complete dated December 9, 2011 revealed, "...total a skin condition report and what care..." to report to the Resident Service Medical record review of a Chart Note dated September 7, 2011 revealed "...was found on Director. floor...hit...head...no redness or bruising..." Medical record review of Chart Notes dated December 11, 2011 revealed, "Took to room after lunch and resident slid out of chair and was on floor...gash on left side of head...to If continuation sheet

(X3) DATE SURVEY Division of Health Care Facilities (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES C IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 03/01/2012 B. WING. TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37115 ELMCROFT OF TWIN HILLS (X6) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX TAG The Resident Service Director D801 Continued From page 48 completed skin condition reports D 806 hospital...returned, spoke with Dr. (doctor) stated on all residents March 29, 2012 he put staples in...head..." through April 4, 2012. Medical record review of an Emergency Provider Report dated December 11, 2011 revealed, "...fell out of wheelchair...1.5 cm (centimeter) lac (laceration)...non-ambulatory at Corrective Action: baseline...non-communicative at Skin condition reports will be baseline...stapled..." reviewed by the Quality Assurance . Observation on February 8, 2012 at 8:58 a.m. revealed Medical Technician (MT) #2 assisted Committee consisting of the the resident to an upright sitting position, held the Executive Director, Resident resident in the upright sitting position, and the facility's Quality Services Manager administered Services Director, Resident medication to the resident. Continued observation Services Coordinator, revealed MT #2 physically lifted the resident and Maintenance Director, Dining placed the resident onto the bed. Services Director, Business Office Review of an Acuity Discharge Planning report Coordinator and Healthy Lifestyles dated December 9, 2011 provided by the 4-10-1 Executive Director on February 7, 2012 revealed Director, monthly. the facility determined twenty-six residents required "Immediate Move-out." Continued review revealed the following: Resident #2: needs secure unit Resident #5: Hospice; Total Care Resident #6: Total Care Resident #7: 104 years old; hospice; total care Resident #8: Non-ambulatory; total care Resident #9: Wound on heel Resident #24: Total Care Resident #25: Non-ambulatory Resident #26: Non-amb (non ambulatory), two person transfer - Hospice Resident #27: Needs secure unit Resident #28: Total Care... Resident #29: Total Care... Resident #30: Two person tranfer if continuation sheet

| Division | of Health Care Faci | lities | | | | (X3) DATE SU | IRVEY |
|--------------------------|---|--|---|------------------------------|---|--|--|
| STATEMENT | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIE | R/CLIA | 1 | LE CONSTRUCTION | COMPLE | TED |
| AMU PLAN C | OF CORRECTION | IDENTIFICATION NUM | MOCIA | A. BUILDING B. WING | | | /2012 |
| | ; | TNPL53766 | | | | 03/0 | 1/20 12 |
| NAME OF P | ROVIDER OR SUPPLIER | | | DRESS, CITY, STATE, ZIP CODE | | | |
| ELMCRO | FT OF TWIN HILLS | | 94 TWIN H MADISON | HILLS DRIVE , TN 37115 | · | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | OFD RE | (X5) COMPLETE DATE |
| D 806 | Continued From pa | age 49 | | D 806 | D806 | | |
| - | Resident #31: 0 Resident #32: T Resident #33: B | Confused; non-ambul otal Care Blind; Total Care Vanders; needs secu | | | Corrective action for residen affected: Residents | <u>ts</u> | |
| | Resident #38: 0 | Confused; total care | • | | #2,5,6,7,8,9,24,25,26,27,28,2 | 19,30, | |
| | Resident #39: N | ion-ambulatory | | ' | 31,32,34,37,38 and 39 have | been | and a service of |
| | ' | | : | | discharged from this facility. | | 77.00 |
| | 79 J | to the facility and s | iatod | | Number 33, 40 and 11 are in | | 1.44 |
| | Review of a letter t | from the facility and or revealed, "Notice of | f | | process of discharge. | | 1 19 19 19 19 19 19 19 19 19 19 19 19 19 |
| | January 18, 2012 revealed, "Notice of Discharge and Transfer(Resident #39)has needs that cannot be safely and effectively met in the Community (assisted living facility)" Review of letters from the facility and dated January 19, 2012 revealed, "Notice of Discharge and Transfer(Residents #8, # 24, #25, #26, #27, #28, #29, #30)has needs that cannot be safely and effectively met in the Community" | | | - | Other Residents that could potentially be affected: | eg ta e i daneg e i daneg e i daneg | |
| | | | | | Per the Elmcroft policy, residually will be provided sufficient st meet their needs. As stated regulations, 1200-08-2512 | aff to in the under | The second secon |
| | January 20, 2012 (| rom the facility and d | f · | | Resident Records, page 32 n 4; An ACLF shall complete a written assessment of the re | | |
| | #40)Notice of Dis needs that cannot the Community" | insfer(Residents #3 scharge and Transfe be safely and effecti (The Discharge Acc | rhas vely met in cuity | | to be conducted by a direct staff member within a time- determined by the ACLF, bu | care period | and the second |
| | Planning Report di include Resident # | ated December 9, 20 40.) | na dia not | | later than seventy two (72) after admission; however in | hours | 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - |
| ٠. | January 30, 2011 residents identified dated December 9 (#5, #6, #7, #8, #1 | ity's current census of revealed eighteen of the facility in the state of the facility in the state of the facility in the state of the facility in the state of the facility in the state of the facility in the state of the facility is state of the facility in the facility in the facility is state of the facility in the facility in the facility is state of the facility in the facility in the facility is state of the facility in the facility in the facility is state of the facility in the facility in the facility is state of the facility in the facility in the facility is state of the facility in the facility in the facility in the state of the facility in the facility in the facility in the facility in the state of the facility in the state of the facility in the facility in the state of the state of th | the report he facility 8, #29, | | reasonable opportunities a Ilcensed nurse conducts the assessment per our policy. not acceptable practice for Community Relations Direc | lt is 😇 | |
| Division of H | iealth Care Facilities RM | | | csss G | SQB511 | If confinua | llon sheet 50 of |

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE ELMCROFT OF TWIN HILLS MADISON, TN 37115 (X5) COMPLETÉ PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES PREFIX (X4) ID DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) . TAG **DEFICIENCY** TAG conduct an assessment. A licensed D 806 Continued From page 50 D 806 nurse doès an assessment per our Interview with the Executive Director (ED) on policy prior to move in, after 30 January 30, 2012, revealed the facility was in the process of moving some residents from the days, every 6 months or upon a second floor to the first floor to improve change of condition or return from evacuation time. an alternative setting such as, Interview with the Chief Operating Officer (COO) hospital, rehab/skilled care or on January 31, 2012 at 9:00 a.m. in the Executive home dependent upon the Director's office revealed, "...facility has residents needs as determined by twenty-two residents on a list to discharge to more appropriate level of care...we considered the level of care assessment. closing this...(facility) because things were so . bad." On March 8, 2012, all existing Interview with the ED on February 1, 2012 at 2:10 residents were assessed by p.m. revealed the facility was acquired by a new licensed nurse per the policy to owner on August 1, 2011; she began as ED during the last week of October, 2011 and she ensure their appropriateness for stated, "...The first couple of days some residents Assisted Living. were inappropriately placed and began process of notifying families...created acuity log. We had to put together a letter to notify residents/families of need to move to another level of acuity...by early part of December, 2011 residents were assessed on our level of care assessment and service plans driven by that...We knew from (acuity log dated December 9, 2011) (on) January 17 (2012) who would need to go..." Telephone interview with the Senior Vice President of Resident Services on February 1, 2012 at 2:40 p.m. revealed, "...Facility has been handed years of issues. (Facility) went through assessment who's appropriate and who's not appropriate...only so much we could do so quickly..." Interview with the Chief Operating Officer (COO) on January 31, 2012 at 9:00 a.m. in the ED's office confirmed the facility had failed to

| Division | of Health Care Fac | llities | | | | (X3) DATE SUI | RVEY | |
|--------------------------|--|---|--|---------------------|---|---|------------------|--|
| | OF DEFICIENCIES | AN PROVIDER/SUPPLIE | R/CLIA | | E CONSTRUCTION | COMPLET | ED | |
| AND PLAN C | F CORRECTION | IDENTIFICATION NUI | MBER: | A BUILDING | | C | | |
| | | TND 20700 | | B. WING 03/01/2012 | | | | |
| | | TNPL53766 | STREET ADD | RESS, CITY, ST. | ATE, ZIP CODE | | | |
| NAMEOFP | ROVIDER OR SUPPLIER | • | 94 TWIN H | ILLS DRIVE | | | | |
| ELMCRO | FT OF TWIN HILLS | , | MADISON | TN 37115 | | | (X5) | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | /DEC DE 1 | COMPLETE DATE | |
| | | | | D 806 | Measures and systematic ch | <u>ianges</u> | | |
| D 806 | Continued From p | its the facility had def | ermined | - | to prevent recurrence; | • | | |
| | discharge residents the facility had determined required care the facility could not provide. He stated, "facility has twenty-two residents on list to discharge to more appropriate level of care. This is not our standard of care" Interview with | | | | The facility has weekly at ris | k calls | | |
|] | | | | | which are designed to discu | ss the | | |
| | | | | · [| resident Quality Services as | | | |
| | tha COO an Fabri | narv 10. 2012. at 234 | յ թ.ա. աւ | | documented on a log, drive | n by | 4.5 | |
| } | the marketing offi | ce revealed "if the s would like it to be so | oner than | | the Quality Service Manage | r to | 1 .: | |
| j | later" | Afodia into it is a | | | monitor the Resident Service | ces · | | |
| | | | | | Director and Executive Dire | ctor | - Service and | |
| 1 | C/O: # 28393 | | | | This meeting is to ensure th | | | |
| D 000 | 4000 09 25- 09 / | 1) Building Standards | 3 | | facility can meet the acuity | leveis | Section of | |
| D 90 | ļ | | | | of the residents. | | 1 | |
| | maintain the condithe overall ACLF such a manner thresidents are assembled. This Rule is not Based on observing failed to maintain | met as evidenced by ration and interview, t the physical conditionsisted Care Living Fo the safety of both res | plant and ment in II-being of the facility on of the acility) | | A Resident Service Coordin position was added on Feb 16, 2012 to be responsible scheduling with a primary staffing. The staffing is determined by the number residents being serviced as individual care plan needs. Resident Service's Coordin reports directly to the Res | for focus of r of nd their . The nator | Section 1 | |
| | revealed a pene detector within re The finding was | February 12, 2012 at tration around the smoom 242 'A'. acknowledged by the deverified by the Mainterview on 2/2/12. |) } | | Service Director. The Resi Service Director will review sample of the care plan's per week for the next 6 w ongoing as needed. The Executive Director an Resident Services Directo | w a one time reeks and id r check | inton sheet 50 | |
| | | | | | | if continu | lation sheet 57 | |

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING **B. WING** 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETE .DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) the staffing model to ensure it is D806 sufficient to meet the acuity needs of the residents. Labor hours are reviewed Monday through Friday with Executive Director, Resident Service Coordinator and Resident Service Director to ensure adequate staffing is utilized. This system is monitored weekly by reporting during the regional operations call with the Regional Director of Operations and Quality Service Manager **Corrective Action:** The level of care assessment which is completed prior to move in, after 30 days, every 6 months or upon a change of condition or return from an alternative setting such as, hospital, rehab/skilled care or home, and labor hours will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles 4-10-12 Director, monthly.

| DIVISION | <u>i of Health Care Haci</u> | littes | | | · · · · · · · · · · · · · · · · · · · | 1 | | |
|--------------------------|------------------------------------|--|------------|-------------------------------------|--|---------------|--|--|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED C | |
| | | TNPL53766 | | B. WING_ | 03/01/ | 2012 | | |
| NAME OF E | PROVIDER OR SUPPLIER | IMP COST GO | STREET ADI | REET ADDRESS, CITY, STATE, ZIP CODE | | | 4. | |
| | OFT OF TWIN HILLS | 94 TWIN I | | | ILLS DRIVE | | · · · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE .DATE | |
| | | | | D901 | 901 | | | |
| | | | | | Corrective action for reside affected: | ents . | - | |
| | • | | j | | The penetration around a s | moke | | |
| | | • · | : | | detector within room 242A | has | and the | |
| | • | | | | been corrected. | | ولائنگام فرنیم مدوسات در آن آن کارور میگیرید در آن آن کارور میگیرید | |
| | | ** | | | Other Residents that could | . | | |
| | | | | 1 | potentially be affected: | 1 | | |
| | | ()· | | | The Maintenance Director I | برادن nas | การเก็บ ประชาชา | |
| | ٠ | / | | | checked the building for | | | |
| | | | ĺ | | penetrations and will contin | nue on | | |
| | • | | | *~* | the preventative maintenar | 4 | | |
| | | • | | | monthly checks. | | The second secon | |
| | | • | | | Measures and systematic c | hanges : | | |
| | | | | | to prevent recurrence: | | | |
| | | , | | · - | The Maintenance Director of | hecks | | |
| | • | | | | for penetrations in the facil | ity | | |
| İ | • | | | | during monthly preventativ | | | |
| | | | į | | maintenance checks and re | ports | | |
| | | | | | findings to the Executive Di | rector. | | |
|] [, | | | | | The Executive Director does | spot | | |
| 1 | | • | | | checks weekly during facility | , | | |
| ļ | • | | 1 | • | rounds to ensure there are | no , | nathay chi. | |
| | | | | | penetrations. | · # | 145 | |
| | | | | | | | | |
| 1 | | - - | <u> </u> | | | | | |

| Division | n of Health Care Fac | llitles | | | <u> </u> | | A STATE OF THE STA |
|--------------------------|---|---|------|------------------------------------|---|-------------|--|
| STATEMEN | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULT A. BUILDIN B. WING | | | ETED · |
| | | TNPL53766 | | | | 03/0 | 1/2012 |
| NAME OF F | PROVIDER OR SUPPLIER | | ? | | STATE, ZIP CODE | | · |
| ELMCRO | OFT OF TWIN HILLS | | | HLLS DRIV , TN 37115 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE |
| - | | • | - | D901 | Corrective Action: | • | |
| | | | | | The penetration tracking w | ill be | i |
| | · | | | | reviewed by the Quality As | | |
| | | | 1 | | Committee consisting of the | | |
| | • | | 1 | | Executive Director, Reside | | |
| | | • | . : | | Services Director, Resident | | . 5-3.552-5. |
| | - | | ' . | | Services Coordinator, | | ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ |
| | | | . | | Maintenance Director, Din | ing | ļ |
| | | - | 1 | | Services Director, Business | Office | |
| | | | . | | Coordinator and Healthy L | ifestyles 🥇 | 1. |
| | · | · · · | | | Director, monthly. | | 4-10-12 |
| | 1 | 5 | | | • | | . 4-10-12. |
| . | V | V | | ~4 | | • | |
| 1 | • | | | | | | |
| . | | | | | | | M. Parista |
| 1 | | | | | | | - 0.4 % |
| | | | | | | | |
| | | | | | | | • |
| . | | | , | | | | |
| 1 | • | | } | | | | |
| 1 | | | | | | | |
| | | | - | (| | | |
| · [| | | | | • | | • |
| <u> </u> | | | | ſ | | | |
| | • | • | | | • | | |
| | • | | | . | , · | . | Attack to the second |
| | | | | | | • | 2.5 |
| | | - | | | | | |
| | | • • | - | | | | |

| <u>Division</u> | <u>of Health Care Fac</u> | lities | | | <u> </u> | (X3) DATE SUF | ₹VEY |
|--|---------------------------|---|-----------------------------|----------------------------|--|-----------------|---|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIE | R/CLIA | (X2) MULTIPL | LE CONSTRUCTION | COMPLET | ED |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUI | MBEK: | A BUILDING | | C | |
| | | TNPL63766 | | | | 03/01/ | 2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TATE, ZIP CODE | · .: | , |
| | FT OF TWIN HILLS | | 94 TWIN H MADISON | IILLS DRIVE , TN 37115 | | | <u> </u> |
| (X4) ID PREFIX TAG | ÆACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL] | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | NUU BE I | (X5) COMPLETE DATE |
| D4004 | 1200-08-2510 (1) | Life Safety | | D1001 | D1001 | | |
| . 01001 | | | | | a | nte | |
| | (1) The department | nt will consider any A | CLF that | | Corrective action for reside | <u> </u> | · |
| | complies with the I | required applicable brons at the time the Bo | uliding and baid | | affected: | | |
| | adopts new codes | or regulations, so lot | ng as such i | | The double doors on the N | orth | |
| compliance is maintained (either with or wasvers of specific provisions) to be in compliance with the requirements of the in | | ntained (either with o | r without | | West and South West halls | have | n de la la la companya de la companya de la companya de la companya de la companya de la companya de la company La companya de la companya de |
| | | e new | | been corrected to ensure t | hey | The straight of | |
| | codes or regulation | | | | open in the direction of tra | vel. | |
| | | | | | Other Residents that could | | |
| | THE STREET | not mot an auldance | nd hve | | potentially be affected: | | and the first |
| | Rased on observa | not met as evidence tion and interview, th | e facility | . ! | DOLCHICALLY NO. | ÷. · | 79 12 E |
| | falled to comply wi | ith applicable building | oplicable building and fire | | The Maintenance Director | | 700 |
| | safety regulations. | | | | checked the fire doors thro | | |
| | The findings include | ded: | | | the facility to ensure they | pen In | - 1-4-1-47-1- |
| | | | (0 =£ 40)24 |] | the direction of travel. | | 1 12 ES |
| | AM, revealed one | g the fire drill on 2/2/ of each of the double | doors on | | . Measures and systematic | changes | |
| | the North West an | d the South East hal on of travel, while the | ls did not same | | to prevent recurrence: | | |
| | doors could each | be opened from the | other | | The Maintenance Director | chacks | |
| | direction. | • | | | | CHECKS | 1 |
| | This finding was a | cknowledged by the | | | fire doors during monthly preventative maintenance | chocks | |
| • | Administrator and | verified by the Maint | enance | | and reports findings to the | | 40.0 |
| | Director during into | erview on 2/2/12. | | | Executive Director. | | , , , |
| • | C/O: #28393 | | | | Executive Director. | | |
| D1024 | 1200-08-2510 (5 |)(c) Life Safety | | | Corrective Action: | | |
| | (5) An ACI E chal | take the following p | recautions | [| The fire door tracking will | | 12.00 m |
| | regarding electrica | al equipment to ensu | e the | | reviewed by the Quality A | | |
| | safety of residents | : | 1/ | P | Committee consisting of t | 1e | |
| | (c) Maintain ail el | ectrical equipment in | good | | | | <u> </u> |

| Division | of Health Care Fac | lities | | 1 | | (X3) DATE SURVEY |
|--------------------------|---|---|-----------------------|------------------------|--|---|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIE | R/CLIA | l' | LE CONSTRUCTION . | COMPLETED |
| AND PLAN L | F CORRECTION - | DEMINIONIONING | MOTIC. | A. BUILDING B. WING | | C 00/04/2042 |
| | | TNPL53766 . | | | | 03/01/2012 |
| NAME OF P | ROVIDER OR SUPPLIER | <u> </u> | | | TATE, ZIP CODE | |
| ELMCRO | FT OF TWIN HILLS | | 84 TWIN H MADISON, | ILLS DRIVE TN 37115 | | |
| (X4) ID PREFIX TAG | . /EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | DED BE COMMETCES |
| D1024 | Continued From pa | age 53 | | - | Executive Director, Resident | |
| | repair and safe op | erating condition; | - | 1 | Services Director, Resident | |
| • | Topul dia buis sp | | ļ | | Services Coordinator, | |
| | | | | 1 | Maintenance Director, Dining | |
| | - | | | - | Services Director, Business Of | fice |
| | This Rule is not m | et as evidenced by: | | | Coordinator and Healthy Lifes | tyles |
| | failed to maintain of condition for three | tion and interview, the call lights in safe oper residents (#21, #22, | rating #23) of | | Director, monthly. | |
| | thirteen resident or maintain the electr | all lights observed an | d falled to : | | | |
| | The findings includ | ded: | | D1024 | D1024 | |
| | Observation with t | he Maintenance Dire | ctor on | 52 02. | | |
| | February 1, 2012 I | between 10:50 a.m. a | and 11:02 | | Corrective action for reside | nes . |
| | a.m. revealed a ba | athroom call light and idents' beds in Room | 235 did | | <u>affected:</u> | |
| | not function. Conti | nued observation rev | realeď a | | Residents #21, 22, and 23's | call |
| | bathroom call light Room 237 did not | and an overbed call | ngat in | | lights have been repaired ar | id are |
| • | , | | | | functioning properly. | |
| | Interview with Med | lication Technician (l 2012 at approximate | Med Tech) Ju 10:51 | | | uros In |
| | #1 on February 1, a.m. in a second f | loor corridor revealed | l a pager in | | Lens covers for the light fixt | |
| | the Med Tech's po | ssession sounded W | nen a | . | rooms 209, 232, 242, 245, a | 130 230 |
| | bathroom call light | was utilized and the intinued interview rev | pager ealed the | | have been replaced. | |
| | light had not soun | ded, and observation | and . | | Other Residents that could | 2 E 30 1 |
| | interview confirme | d the pager had not I | recorded | <u> </u> | potentially be affected: | |
| | the call from Roon | n 235. | | } | | - 100,000 |
| | Interviews with the | Maintenance Direct | or on | . | The Maintenance Director | |
| | February 1, 2012 | at approximately 11:0 |)0 a.m. | | checked light fixtures throu | gnout |
| | and 11:04 p.m. in | a second floor corrid lights were not in sa | fe | | the building to ensure they | nau |
| | operating condition | n. | | | lens covers in place on Mar | UII 20, |
| | On 010140 of 44145 | AM, observation wi | hin | | 2012. | 12 10 10 10 10 10 10 10 10 10 10 10 10 10 |
| | resident rooms 20 | 9, 232, 242 245 and | 256 | 1 | · | |

If continuation sheet 54 of

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D1024 The Maintenance Director will D1024 Continued From page 54 check light fixtures monthly to revealed the lens covers for the light fixtures were missing, ensure they have lens covers and report findings to the Executive The findings were acknowledged by the Administrator and verified by the Maintenance Director. Director during interview on 2/2/12. Corrective Action: C/O: #28393, #28241, #29068 The lens cover tracking will be D1035 1200-08-25-.10 (8)(a) Life Safety reviewed by the Quality Assurance Committee consisting of the (8) An ACLF shall ensure that: Executive Director, Resident (a) The ACLF maintains all safety equipment in Services Director, Resident good repair and in a safe operating condition; Services Coordinator, Maintenance Director, Dining This Rule is not met as evidenced by: Services Director, Business Office Based on observation, testing, and interview, the Coordinator and Healthy Lifestyles facility falled to maintain the safety equipment. Director, monthly. The findings included: Observation during the fire drill on 2/2/12 at 10:35 a.m. revealed the fire alarm strobes were not synchronized. D1035 D1035 On 2/2/12 at 11:33 AM, testing of the smoke Corrective action for residents detector in room 242 B revealed the unit was not working. affected: These findings were acknowledged by the The fire alarm strobes will be Administrator and verified by the Maintenance synchronized by an outside Director during interview on 2/2/12. contractor by March 30, 2012. C/O: #28393 The smoke detector in room 242B D1045 1200-08-25-,10 (10)(f) Life Safety has been replaced.

Division of Health Care Facilities

| <u>Divisior</u> | າ of Health Care Faci | ilitles · | | | | | |
|---|-----------------------|--|-----------|---|--|------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
| | | TNPL63766 | | B. WING | | | 1/2012 |
| NAME OF F | PROVIDER OR SUPPLIER | 114 200100 | STREET AD | DRESS, CITY. | STATE, ZIP CODE | | |
| ELMCROFT OF TWIN HILLS | | | 94 TWIN | HILLS DRIV I, TN 3711 | /E . | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | . ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| | | | | D1035 | Other Residents that could potentially be affected: The Maintenance Director I checked the smoke detector resident rooms to ensure the working properly. Measures and systematic of the prevent recurrence: The Housekeepers check designed to prevent detector to be a systematic of the prevent recurrence. | nas ors in ney are hanges | And the second of the second o |
| | | | | *** | during room cleaning for equipment in proper working order to include the light fix. The Maintenance Director of the daily check off sheets for compliance. The Maintenance Director of the Maintenance Director of the Director. | ctures. reviews or vill | |
| | | | | | Measures and systematic contours to prevent recurrence: The strobes will be checked monthly during a fire drill for proper working order and fire will be reported to the Exect Director. | or ndings | |

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 03/01/2012 TNPL53766 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 TWIN HILLS DRIVE ELMCROFT OF TWIN HILLS MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION OX5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX Ю (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX .DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) D1035 The smoke detectors will be checked by the Maintenance Directory monthly during preventative maintenance rounds and findings will be reported to the Executive Director. **Corrective Action:** X The strobes and smoke detectors will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining remarké e Services Director, Business Office Coordinator and Healthy Lifestyles 4-10-12 Director, monthly. D1045 D1045 Corrective action for residents affected: Air return grilles and air supply diffusers will be cleaned and in compliance no later than 3-30-2012.

Division of Health Care Facilities

STATE FORM

| Division | of Health Care Facilities | | T | | (X3) DATE SURVEY | |
|--|---|---------------------------|---|---|--|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | COMPLETED | |
| | | | | | | |
| | <u></u> | STREET ADI | DRESS, CITY, S | TATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | HILLS DRIVE | | | |
| ELMCRO | FT OF TWIN HILLS | MADISON | TN 37115 | 1 | | |
| nt 11 15 | SUMMARY STATEMENT OF DEFICIENCIE | s | ΙĐ | PROVIDER'S PLAN OF CORRECT | TION (X5) | |
| (X4) ID PREFIX | FACH DEFICIENCY MUST BE PRECEDED BY | FULL 1 | PREFIX TAG | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE | ROPRIATE DATE | |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMA | (ION) | 340 | DEFICIENCY) | | |
| D1045 | Continued From page 55 | | D1045 | Other Residents that could | | |
| D1045 | , - | | | potentially be affected: | ' | |
| | (10)An ACLF shall maintain its physical environment in a safe, clean and sanita | n mannet | | potentially be ancescar | | |
| | by doing at least the following: | ty mannor | • | Air return grilles and air sup | ply | |
| | | lina | | diffusers will be cleaned and | i in | |
| | (f) Maintain the building and its heating plumbing and electrical systems in good | 3, cooling, i direpalr | 1 | compliance no later than 3- | 30 . | |
| | and in clean condition at all times; and | a ropun | | 2012. | | |
| | | LSC | <u> </u> | | | |
| | This Date is not maken evidenced by | V -/ | | Measures and systematic c | <u>hanges</u> | |
| | This Rule is not met as evidenced by: Based on observation and interview, the | e facility | } | to prevent recurrence: | | |
| | falled to maintain the building and heal | ing | | ma a a a a a a a a a a a a a a a a a a | | |
| | system in good repair and in clean cond | dition. | | The Maintenance Director v | ************************************** | |
| | The findings included: | | | have housekeeping maintal | 5 | |
| | • | • | ,] | air return grilles for cleanlin | ess | |
| | On 2/2/12 at 11:45 AM. observations w facility revealed the air return grilles and | ithin the | | daily. | | |
| | supply diffusers were dirty. | . •••• | | The Maintenance Director v | vill | |
| | | | | monitor compliance and re | port port | |
| | This finding was acknowledged by the Administrator and verified by the Mainte | enance | | findings to the Executive Di | 42.55.44 | |
| | Director during interview on 2/2/12. | | 1 | Commenting Actions | | |
| | C/O: #28393 | | | Corrective Action: | | |
| | | | | Air return grilles tracking w | ill be | |
| D1206 | 1200-08-2512 (2)(e) Resident Record | | reviewed by the Quality Ass | | | |
| | | | | Committee consisting of th | | |
| | (2) Personal record. An ACLF shall er the resident's personal record include | isuie iliai s af a | | Executive Director, Residen | 1 | |
| | minimum the following: | | , | Services Director, Resident | | |
| | , | | | Services Coordinator, | | |
| | (e) Date of admission, transfer, discha | rge ano | | Maintenance Director, Dini | ng l | |
| | any new forwarding address; | | | Services Director, Business | | |
| | • | | Coordinator and Healthy Li | | | |
| | This Rule is not met as evidenced by: | iour and | | | 4-10-12 | |
| | Based on medical record review, interviewel facility facsimile documentation | on, the | | Director, monthly. | | |
| | facility failed to document the date of a | dmission | | · | -275 | |
| | | | | | | |

(XS) DATE SURVEY Division of Health Care Facilities COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 03/01/2012 B. WING TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37116 ELMCROFT OF TWIN HILLS (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY TAG TAG D1206 D1208 D1206 Continued From page 56 Corrective action for residents for one resident (#4) of twenty residents affected: reviewed. Resident #4 has been discharged The findings included: from the facility to a higher level Medical record review (Resident #4) of a Personal Data and Contact Sheet revealed the of care. The admission date was date of admission was blank. obtained on March 29, 2012 by A request for documentation for Resident #4's the Executive Director for this date of admission was made to the facility's resident and added to the file as Quality Services Manager on February 10, 2012 at 12:02 p.m. Interview with the Quality Services an addendum. Manager on February 12, 2012 at 12:02 p.m. In the Marketing Office revealed the requested Other Residents that could documentation would be faxed to the State potentially be affected: Agency. The resident information sheet for Review of facsimile (fax) documentation provided by the facility on February 13, 2012 at 1:49 p.m. new move-ins prior to or on the confirmed the facility failed to include the date of move-in to include the resident's date of admission on the resident's state required information, such Personal Data and Contact Sheet and included, "...Date of admission: unable to find..." as admission and discharge/transfer dates and any D1212 1200-08-25-.12 (3)(c) Resident Records new forwarding addresses will be completed by April 10, 2012. (3) Medical record. An ACLF shall ensure that its Current residents have a resident employees develop and maintain a medical record for each resident who requires health care Information sheet in their services at the ACLF regardless of whether such Resident care chart. The Elmcroft services are rendered by the ACLF or by arrangement with an outside source, which shall standard of organized files will be followed. The current resident include at a minimum: records will be reorganized in (c) Orders and recommendations for all medication, medical/and other care, services, chronological order per Elmcroft procedures, and diet from physicians or other standards by April 10, 2012. authorized healthcare providers, which shall be completed prior to, or at the time of admission, If continuation sheet

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING C B. WING_ 03/01/2012 TNPL53766 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X6) COMPLETE PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE. REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D1206 Measures and systematic changes to prevent recurrence: The resident information sheet for new move-ins is done prior to or on the date of move-in to include the state required information, such as admission and discharge/ transfer dates and any new forwarding addresses. The Community Relations Director will complete the resident information sheet prior to or on the date of move-in as per the policy. The Executive Director will monitor for compliance by doing random monthly audits to include at least 2 charts per month. The facility has weekly at risk calls which are designed to discuss the resident Quality Services as documented on a log, driven by the Quality Service Manager to monitor the Resident Services Director and Executive Director. This meeting is to ensure the facility can meet the acuity levels

Division of Health Care Facilities

of the residents and includes

| Division | Division of Health Care Facilities (X3) DATE SURVEY | | | | | | | | | |
|---|--|--|-----------------------|-------------------------|--|-------------|--------------------|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | MAN BROWINER/SUPPLIER/CLIA | | 1, , | LE CONSTRUCTION | COMPLET | TED | | | |
| | | IDENTIFICATION NUN | WDER: | A. BUILDING | | 03/01 | /2012 | | | |
| | | TNPL53766 | | ı | | 1 | , . | | | |
| NAME OF D | ROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, ST | FATE, ZIP CODE | | | | | |
| 1 | FT OF TWIN HILLS | | 94 TWIN H MADISON. | IILLS DRIVE TN 37115 | | | | | | |
| ELWCRO | | | L | - | PROVIDER'S PLAN OF CORRECT | TION | (X6) . COMPLETE | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PREFIX TAG | REFIX (EACH CORRECTIVE ACTION OF | | DATE | | | |
| ļ | Denting 5 | 200 57 | | D1206 | tracking information for the | new | | | | |
| D1212 | l. · | • | Lordero | 52200 | move-in's and move-out's. | | | | | |
| | received shall inclu | as warranted. Verbal ude the time of receip of the order, and iden | ון שוווסוג | | Corrective Action: | | | | | |
| | order, description of the individual re | celving the order; | | | The resident information sheet | | | | | |
| | . | | | 1 | Ine resident information sit | tion | | | | |
| | | | . 1 | 1 1 | and at risk tracking information will be reviewed by the Quality | | | | | |
| 1 | This Rule is not n | net as evidenced by: | v of facility | 1 . | will be reviewed by the Qua Assurance Committee consi | isting | | | | |
| | Based on medical record review, review, facsimile documentation, and interview | | .eAlem of facility [| | of the Executive Director, R | esident | 1 | | | |
| | I facility failed to ma | aintain a medical recu | յլն ա | 1 | Services Director, Resident | | 1. 1. 1. | | | |
| | include physician's order to transfer to a nospite | | а поѕрікаі | 1 | Services Coordinator, | | 4-34 | | | |
| | I for evaluation/trea | evaluation/treatment for five residents (#1, #2, #5, #15) of twenty residents reviewed. | | 1 | Maintenance Director, Dini | ng "·· | VIII A | | | |
| | { | | | | Services Director, Business | Office | 1 | | | |
| | The findings include | ded: | | 1 | Coordinator and Healthy Li | festyles | | | | |
| | Resident #1 was a | admitted to the facility | y with | | Director, monthly. | | 4-10-12 | | | |
| | il disanoses includit | diagnoses including Dementia and Deger Joint Disease. Medical record review of a | | 1 | Directory mercury | | | | | |
| | Joint Disease, Me | edical record review of the months of the contract of the cont | led. "fell | 1 | | | + . w ₁ | | | |
| | I hit t /leff\ side of l | headtransported to view revealed no doc | ⊓ospitat• | D1212 | D1212 | | | | | |
| 1 | regarding a physic | iclan's order to transfer th | er the | | Corrective action for resid | <u>ents</u> | 1 | | | |
| .] | resident to the ho | spital. | | | affected: | | | | | |
| 1 | Interview with the | Resident Services D | lirector on | | | r h | | | | |
| | 1 tomuson 20 2012 |) at 12:20 n.m. in the I | markeuny | | Residents #1, 2, 3, 5 and 1 | o nave | 11.00 | | | |
| † | Letter confirmed | the facility talled to or | Dialii Olaeis | ? | been discharged from the | racility. | 1 | | | |
| | to transfer the resident to a hospital of 11, 2011. | | | | | | | | | |
| | | | | 1 | Other Residents that coul | ₫. | | | | |
| | Resident #2 was admitted to the facility on | | to the facility on | | potentially be affected: | | 1 | | | |
| } | October 12, 2010 | with diagnoses inclu | ıding | | | | | | | |
| | Dementia. | | | | Physician's orders are now | OW :3 | | | | |
| | Medical record re | eview of a Chart Note | dated | | obtained to transfer reside | - | | | | |
| 1 | I December 24, 20 | 141 at 10:00 p.m, (ev | 'eareu _i | | the hospital. | · | | | | |
| | "Resident discov | ered by care attendar | IIIwas | <u> </u> | 1 | | 37.33 24.50 | | | |

(X3) DATE SURVEY Division of Health Care Facilities (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 03/01/2012 B. WING TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37115 ELMCROFT OF TWIN HILLS (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY TAG PRÉFIX TAG The Elmcroft policy will be D1212 Continued From page 58 followed to complete the D1212 Physician's Plan of Care for new bleeding from nose, ear, mouth, and jaw appeared to be swollen...Resident sent to ER . resident admissions prior to or on (Emergency Room)..." Medical record review the date of the admission. This Is revealed no documentation regarding a physician order to transfer the resident to the hospital. completed by the Resident Service Interview with the Quality Service Manager on Director. February 10, 2012 at 11:47 a.m., in the marketing Measures and systematic changes office, confirmed the facility failed to obtain a physician's order to transfer the resident to the to prevent recurrence; hospital on December 24, 2011. The Resident Service Director inserviced staff on obtaining a Resident #3 was admitted to the facility with diagnoses including Hypertension and physician's order to transfer residents to a hospital March 20, Parkinson's Disease. 21 and 22, 2012. Current Medical record review of a Chart Note dated June 18, 2011 revealed, "(Resident) was sent out to have a physician's residents Hospital do (due) to fall..." Medical record review plan of care with a standing order revealed no documentation regarding a to transfer resident to the hospital physician's order to transfer the resident to the in the event of an emergency. hospital. Interview with the Resident Services Director on The physician's plan of care will be February 1, 2012 at 9:30 a.m. in the Executive tracked by monthly audits of Director's office, confirmed the facility falled to medical records to ensure they are obtain a physician's order to transfer the resident to a hospital on June 18, 2011. in compliance. Resident #5 was admitted to the facility on Corrective Action: September 9, 2011 with diagnoses including The physician's plan of care audits Pick's Disease. Medical record review of a Chart Note dated will be reviewed by the Quality December 11, 2011 revealed, "...slid out of chair Assurance Committee consisting and was on floor...gash on left side of back of of the Executive Director, Resident head...to (hospital)..." Medical record review revealed no documentation regarding a If continuation sheet !

(X3) DATE SURVEY. Division of Health Care Facilities COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES С IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION 03/01/2012 B. WING TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37115 ELMCROFT OF TWIN HILLS (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY TAG TAG Services Director, Resident D1212 Continued From page 59 Services Coordinator, D1212 physician's order to transfer the resident to the Maintenance Director, Dining Services Director, Business Office hospital. A request for documentation regarding a Coordinator and Healthy Lifestyles physician's order was made to the facility's 4-10-12 Quality Services Manager on February 10, 2012 Director, monthly. at 12:08 p.m. Review of facsimile (fax) documentation provided. by the facility and dated February 13, 2012 at 1:49 p.m. confirmed the facility failed to obtain a physician's order and included, "...no order to transfer out due to fall..." Resident #15 was admitted to the facility on June 1, 2011 with diagnoses Including Stage IV Pressure Ulcer. Medical record review of a Chart Note dated January 9, 2012 revealed, "...having difficulty obtaining blood pressure...transported to (hospital)..." Medical record review revealed no documentation regarding a physician's order to transfer the resident to a hospital. Interview with the Executive Director (ED) on January 31, 2012 at 11:55 a.m. in her office revealed she was unaware a physician's order was required to transfer an acutely ill or injured resident to a hospital. Continued interview confirmed the facility failed to ensure medical records included physician's orders for Residents #1, #2, #3, #5, and #15. D1222 D1222 1200-08-25-.12 (4) Resident Records (4) An ACLF shall complete a written assessment of the resident to be conducted by a if continuation sheet 6

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 03/01/2012 B. WING TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE MADISON, TN 37115 ELMCROFT OF TWIN HILLS PROVIDER'S PLAN OF CORRECTION COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG D1222 D1222 Continued From page 60 D1222 Corrective action for residents direct care staff member within a time-period determined by the ACLF, but no later than affected: seventy-two (72) hours after admission. Resident's #1, 3, 4,5,6,7,8,9,13,14 and 15 have been discharged from This Rule is not met as evidenced by: Based on medical record review, review of facility the facility. Resident's #10, 11, 12, facsimile documentation, and interview, the 16 and 19 have a written facility falled to timely complete a written assessment for sixteen residents (#1, #3, #4, #5, assessment that is current per the #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, Per the Elmcroft policy, residents #19) of eighteen residents reviewed. will be provided sufficient staff to meet their needs. As stated in the The findings included: . regulations, 1200-08-25-.12 under Medical record review revealed no documentation regarding written assessments within seventy-two Resident Records, page 32 number hours of admission for Residents #1, #3, #4, #5, 4; An ACLF shall complete a #8, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16 written assessment of the resident and #19. to be conducted by a direct care Interview with the Resident Services Director staff member within a time-period (RSD) on January 30, 2011 at 12:20 p.m. in the determined by the ACLF, but no Executive Director's (ED) office confirmed the later than seventy two (72) hours facility failed to complete an assessment for after admission; however in all Resident #1. reasonable opportunities a Interview with the RSD on February 1, 2012 at 9:30 a.m. in the ED's office confirmed the facility licensed nurse conducts the failed to complete an assessment for Resident assessment per our policy. It is not acceptable practice for a #3. Community Relations Director to Requests for documentation regarding assessments for Residents #4, #5, #6, #7, #8, #9, conduct an assessment. A licensed #10, #11, #13, #14, #15, #16, and #19 were nurse does an assessment per our made to the facility's Quality Services Manager policy prior to move in, after 30 (QSM) on February 10, 2012 between 12:08 p.m. days, every 6 months or upon a and 1:12 p.m. change of condition or return from Interview with the facility's QSM on February 10,

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING . 03/01/2012 TNPL53766 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) an alternative setting such as, D1222 D12221 Continued From page 61 hospital, rehab/skilled care or 2012 between 12:33 p.m. and 1:12 p.m. in the home dependent upon the marketing office confirmed the facility falled to complete assessments for Residents #9 and #12. residents needs as determined by the level of care assessment. Review of facsimile documentation provided by the facility on February 13, 2012 at 1:49 p.m. confirmed the facility failed to complete On March 8, 2012, all existing assessments for Residents #4, #5, #6, #7, #8, residents were assessed by #10, #11, #13, #14, #15, #16, and #19. licensed nurse per the policy to C/O: #29068 ensure their appropriateness for Assisted Living. D1223 1200-08-25-.12 (5)(a) Resident Records Measures and systematic changes (5) Plan of care. to prevent recurrence: (a) An ACLF, shall develop a plan of care for. each resident admitted to the ACLF with input The facility has weekly at risk calls . 150 and participation from the resident or the resident which are designed to discuss the 's legal representative, treating physician, or resident Quality Services as other licensed health care professionals or entity delivering patient services within five (5) days of documented on a log, driven by admission. The plan of care shall be reviewed and/or revised as changes in resident needs occur, but not less than semi-annually by the above-appropriate individuals. This Rule is not met as evidenced by: Based on review of the resident census and interview, the facility failed to develop a plan of care for twenty residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16. #17, #18, #19, #20) of twenty residents reviewed. The findings included: Review of the resident census dated January 30, 2012 revealed sixty-nine residents currently resided in the facility and four residents were in a

DIVISION OF Health Care Facilities

GQB511

| Division | of Health Care Fac | llities | | | | <u>,</u> | <u>- `</u> | |
|---|----------------------|---|-----------|---------------------|---|---|-------------------|--|
| S'TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER | | R/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | | | |
| | • | | | B. WING_ | | 03/01/2012 | | |
| TNPL53766 | | | DESC CITY | STATE, ZIP CODE | | | | |
| NAMEOFF | PROVIDER OR SUPPLIER | - | 1 | HLLS DRIVI | • | | | |
| ELMORO | OFT OF TWIN HILLS | | MADISON | TN 37115 | • | | | |
| (X4) ID PREFIX TAG | | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY) | SHOULD BE COMPLETE | | |
| | | | | | the Quality Service Manage | rto | | |
| | | | | D1222 | monitor the Resident Service | es | | |
| | | | | • | Director and Executive Director | tor. | | |
| ļ | , | | . , | | This meeting is to ensure th | e ' \ | | |
| | | • | ; | | facility can meet the acuity | evels | | |
| | | • | | | of the residents | | | |
| | • | | | | Corrective Action: | to make agent | (3) :3. | |
| | | ** | · | | The level of care assessmen | t l | | |
| | | • | | | which is completed prior to | move | | |
| | | | | | in, after 30 days, every 6 mg | ١. | , | |
| • | · | | , | | or upon a change of conditi | | • • • | |
| | • | | | | return from an alternative s | 1 11 17 17 17 | | |
| | | | | | such as, hospital, rehab/skil | 1 . | | |
| | • | _ | | ~ | care or home will be review | 1 | | |
| | ' | • | | | the Quality Assurance Com | L ~ *** | | |
| | • | · | | | consisting of the Executive | H. Carr | , | |
| ļ | | : | | | _ | 200 200 | 2 ³ 42 | |
| | | | | | Director, Resident Services | | | |
| | | | | | Director, Resident Services | | | |
| | | | 1 | | Coordinator, Maintenance | | | |
| | , | | | | Director, Dining Services Dir | | | |
| | • | | | | Business Office Coordinator | and . | | |
| ľ | | | Į | : | Healthy Lifestyles Director, | 4-10-1 | רו | |
| İ | | • | | | monthly. | 4-10-1 | ٠,4 | |
| . | _ | • | 1 | , | | | | |
| ļ | • | | · | | | | ٠. | |
| Ì | | | | | | -ATE-CE S | | |
| | • | | l | | | 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | | |
| ſ | | • | | | , | 1-1-2-1-2-1-2-1-2-1-2-1-2-2-2-2-2-2-2-2 | | |
| | | | | | | | | |
| | | • . | | | | | | |
| | | | | | | | | |

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING Ċ B. WING TNPL53766 03/01/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 TWIN HILLS DRIVE **ELMCROFT OF TWIN HILLS** MADISON, TN 37115 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D1223 Continued From page 62 D1223 D1223 hospital or a rehabilitation facility. Corrective action for residents Interview with the Resident Services Director affected: (RSD) on February 2, 2012 at 12:20 p.m. in the Executive Director's office revealed the RSD Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, determined a resident's needs and 13, 14, and 15 have been communicated those needs to the staff. Continued interview revealed care plans had not discharged from the facility. been developed for any resident. Residents #10, 11, 12,16,17,18 Interview with the Quality Services Manager on and 19 currently have a plan of February 10, 2012 at 12:02 p.m. in the marketing care in the resident's medical office confirmed the facility failed to develop a record. plan of care for twenty of twenty residents. Continued interview confirmed the facility failed to Other Residents that could develop a plan of care for any resident within the facility. potentially be affected: Plan of care documentation has been completed on each resident per Elmcroft policy. This was completed by the Resident Service Director on March 29, 2012. This is called the service plan and is completed by each shift. Measures and systematic changes to prevent recurrence: The service plan is checked by the licensed nurse or supervisor of the shift to ensure assignments are

| Divisio | n of Health Care Fac | littes : | | ·· | | | ÷ | |
|---|--|---|---------------------------------------|--|---|-------------------------------|---------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
| | | TNPL53768 | • | B. WING_ | • | | C 1/2012 | |
| NAME OF PROVIDER OR SUPPLIER | | 1141 250150 | STREET ADDRESS, CITY, STATE, ZIP CODE | | STATE, ZIP CODE | 0010172012 | | |
| ELMCROFT OF TWIN HILLS | | 94 TWIN | | VIN HILLS DRIVE SON, TN 37115 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | . ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOTO CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | COMPLETE TE DATE | |
| • | | | | | properly being carried out. T | his | | |
| | | | | D1223 | information is reported to the | • | | |
| | | | | | Resident Service Director. | | | |
| | | <i>.</i> • | ٠ | | | | \ | |
| | · . | • | | | The Resident Services Directo | | | |
| | | | Ī | i | completes the service plan fo | | | |
| | | • | . : | | each resident upon move-in, | • | منتشند ا | |
| | | | | | using the level of care assessr | | | |
| | | | • | | to determine the services nee | | | |
| • | | | | | The service plan indicates the | ! | | |
| | | | | | services required, and the | | | |
| | | • | - | | methodology in completing th | ne | district. | |
| | | | | | task specific to the individual | | | |
| | _ | | | ٠., | resident. | | : ` | |
| | | | | | Carrective Action: | | Andrews Control | |
| | | | 1 | | The service plans will be revie | wed | ALEMAN . | |
| 1 | | | - | | by the Quality Assurance | | | |
| ľ | • | | | | Committee consisting of the | | | |
| 1 | | • | | | Executive Director, Resident | | | |
| 1 | | | | | Services Director, Resident | | | |
| İ | • | | - 1 | | Services Coordinator, | | | |
| . , | | | | | · Maintenance Director, Dining | | | |
| . | | | 1 | 1 | Services Director, Business Of | fice | | |
| | | | 1 | • | Coordinator and Healthy Lifes | tyles | | |
|]. | | | | ł | Director, monthly. | | 4-10-12 | |
| j | • | | | į | • | | | |
| | • | | | • | · | ÷. | | |
| | | | | | | 1 | | |
| | | • • | | - | | | | |